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Strategic Assessment of the
USAID/Nigeria Child Survival Program
ABUJA, November 2002

EXECUTIVE SUMMARY

As USAID Nigeria moves toward implementation of its new Strategic Plan covering 2004 - 2008, it is working hard to have a comprehensive understanding of the effects of U.S. Government and other donor assistance provided over the past decades. Nigeria has experienced considerable political, economic and social upheaval during recent years.
To maximize future development assistance, it is critical to understand the interactions of domestic dynamics and the way development assistance has contributed to changes to date. New USAID programs and policies must stem from both overall Agency policy and priorities, and the specific needs and capacities that exist in Nigeria.

To contribute to understanding current development status of Nigeria, USAID engaged the services of a team of seven public health experts to provide a strategic assessment of their child survival program. The assessment was conducted from October 24 to November 10, 2002. It included interviews with key government and private sector leaders in health; a review of official program documents and reports; site visits to Lagos and Kano States, and lengthy discussions with USAID officials in HPN and other sectors.

This report provides a synthesis of what was learned; the team's analysis of existing information; and recommendations on how to proceed with child survival programming over the next five years. Nigeria is the largest and single most important country in Africa. As such, we hope this assessment helps facilitate successful efforts by USAID to significantly improve the health status of Nigeria's population.

OVERVIEW

USAID has been involved in Child Survival in Nigeria since the early 1990's. During the years of military rule, USAID maintained a presence in Nigeria, working through the private sector, at a reduced scale and funding levels. The BASICS Project worked through an indigenous NGO network called Community Partners for Health to help communities come together to address their own health issues and create partnerships. The CPH's proved that communities could be successfully mobilized to help themselves in times of crisis. Many of these communities also developed working partnerships with International Partners (IPs) working in reproductive health.

Within months of the transition to a democratic government, the USAID portfolio had begun to grow dramatically. In October 1999, USAID/Nigeria launched a four-year transition strategy, working in Health, Education, Agriculture and Democracy and Governance. The Population/Health/Nutrition Unit has three sub-sectors: child survival, population/family planning and HIV/AIDS. Currently these sub-sectors are managed separately, although considerable effort is being made to foster integration and collaboration.

In the absence of a bilateral agreement with the Nigerian Government, USAID has in the past obligated money through US-based International Partners. While appropriate in its time, USAID/Nigeria now views this arrangement as too management intensive and as reducing their

flexibility. Under the new strategy, USAID will obligate funds through fewer, larger bilateral mechanisms. The Child Survival Strategic Assessment is part of the USAID/Nigeria analytic agenda to inform the new five-year strategy. Companion assessments were done in HIV/AIDS and population/reproductive health and will be done in education and Food Security.

USAID proposes a strategy that will integrate the health and education sectors. HIV/AIDS will receive the largest portion of funding under the new strategy (and be managed under its own Strategic Objective), followed by population/family planning. Activities in both education and child survival will be subject to resource constraints. It is in this context that the team undertook its analysis, because given the magnitude of the child survival issues Nigeria faces, every dollar must be leveraged and/or used to its maximum potential.

ANALYTIC FRAMEWORK

In order to systematize its assessment, analysis, and recommendations, the team developed a framework that was useful in identifying key levels and types of action for USAID investment of resources and efforts. It is compatible with the operational framework developed by UNICEF, one of the main USAID child survival partners and captures several elements of the USAID Strategic Objective framework.

The framework represents the assessment and recommendations the team believes to be important in relation to strategic options for USAID child survival programming. These include:

- Outcomes in three categories - enabling environment, capacity building; and promoting healthy practices;
- Cross-cutting support – encompassing types of investment affecting several child survival or PHN program areas;
- Level of action and responsibility – international, national, state, local and community;
- Activities and interventions – programming approaches and interventions that might be carried out at each level;
- Synergies and Integration – opportunities to integrate programs and interventions.

FINDINGS

A. TECHNICAL PROGRAMS AREAS

1. Malaria: The Roll Back Malaria (RBM) movement in Africa has defined three key strategic interventions reflected in the three Abuja Summit targets: prompt and effective treatment of malaria illness in children under five; access to and use of insecticide-treated nets (ITNs); and intermittent preventive treatment (IPT) in pregnancy. The RBM partnership in Nigeria has drafted a strategic plan that includes these major strategies as well as others. The status and strength of progress in implementation of each varies, with implementation of ITNs as the best developed of these. The RBM strategy of early and effective treatment has moved much more slowly, and the strategy for IPT in pregnancy has not been promulgated.

The current malaria-relevant indicators reported by the mission and its IPs are only partially consistent with RBM and USAID indicators. A DHS planned for early 2003 will include the malaria module that will provide a standard baseline for future program M&E. However, a review of current plans for data collection and reporting by IPs and communities implementing RBM activities would strengthen the Mission's ability to report results for this significant part of its health portfolio.

2. Nutrition: While Nigeria has the potential to produce sufficient food to meet the needs of its population (~130 m) and for export, food production deficits over the past decade have led to widespread food insecurity and malnutrition, especially among women and young children. Malnutrition is further exacerbated by the high burden of infections, lack of safe water and sanitation, inappropriate household dietary and health behaviors, and the effects on women of too frequent child bearing beginning too early in life. Fully a third of Nigerian children are stunted, and rates of anemia among women and young children remain high. The only significant nutrition success story over the past decade has been the achievement of virtually universal iodization of household salt (98%), resulting in dramatically improved iodine status across the population.

Nigerian nutrition policy is comprehensive. It is, however, only a prelude to drafting a more strategic National Plan of Action for Nutrition under the direction of The National Committee for Food and Nutrition (NCFN). Such a strategy must engage key partners in making strategic decisions about program priorities, phasing, roles and responsibilities that will make the national plan feasible to be implemented and supported by all partners. It must include such interventions as vitamin A supplementation; food fortification; and infant feeding.

3. Immunization: Nigeria has a long history of implementing the Expanded Program of Immunization (EPI) starting with pilot efforts in 1975, and revising the strategy in 1984 with major inputs from UNICEF. In 1983, the Government started increasing the inputs: funding, logistics, transport, power generators, IEC materials and training packages, organizing a series of national and state immunization days (NIDs and SIDs). National coverage was less than 15%.

In the last two to three years, immunization activities have focused overwhelmingly on NIDs for polio, based on a global agenda and donor funding. There is very little activity in routine immunization at fixed PHC facilities. The surveillance system for life threatening vaccine preventable diseases (VPDs) and other childhood illnesses also has suffered. Currently, DPT3 coverage is low, and polio NIDs drain resources from routine immunization.

4. Other Child Survival Issues: It is logical for USAID to identify a limited number of program areas to focus its child survival investment. The three areas chosen by USAID (malaria, nutrition and immunization) account for a significant proportion of under five morbidity and mortality and bring earmarked USAID funds. Nigeria is committed to addressing these issues, and other donor funding and international movements (e.g. GAVI, GAIN, RBM, etc.) address them, so leveraging possibilities exist. There is also value in considering the other major causes of child morbidity and mortality. Other areas can be addressed in the context of integrated programs and, in fact, are necessarily addressed at the service delivery level. The major conditions that should considered programmatically are
diarrhea and acute respiratory infections (especially pneumonia). Together, they are estimated to account for over one-third of under five child deaths in Nigeria. Another child survival area worthy of a small, well-defined effort is neonatal mortality. Birth spacing also is a child survival intervention.

B. CROSS CUTTING AREAS

1. Community Approaches: Community approaches are important means to achieve ownership, sustainability and local buy-in where governments have scarce resources. Community approaches need to be backed by observable results including behavioral and structural changes. The assessment team identified the key issues that must be addressed to bring USAID supported community

approaches to meaningful scale: Simplification, streamlining and consolidation;

- Understanding and applying population base coverage and monitoring;
- Achieving a "critical mass" of intervention;
- Focusing on and delivering outcomes; and
- Reaching the hard-to-reach.

2. Child Survival Program Packaging: The primary health care "system" d in Nigeria is designed to provide comprehensive, integrated health care, with a well-coordinated, two-way referral system. In addition, the package is to integrate home/community-based care with clinic-based health care. This is the theory; in practice, the system does not always live up to its design.

A number of health care packages, from the Bamako Initiative to Minimum Health Care Package, BFHI, IMCI and more recently COPE and WCFHS strive to provide comprehensive CS/PHC services. The two most current additions are the CAPA and the Ward Health System (WHS). All these packages were put into operation using well thought out procedure guides or operational manuals. Most are internally consistent and logical. However, there was little coordination among the groups developing different approaches, so the end result is a somewhat fragmented effort. *Many front-line PHC workers received some form of training on the implementation of these packages, and some are confused by changes in the manner CS/PHC services are provided.* PHC packages are usually accompanied by corresponding job aids and BCC materials. There is an enormous amount of experience in these combined efforts**, making harmonization a high priority.**

3. Policy: USAID interacts on the policy front in two ways: directly through USAID officers and indirectly through its IPs. Without even going to state and LGA levels, the number and complexity of stakeholders and government departments engaged in various policy arenas important to child survival is daunting.

The team felt that the overall "policy environment" at the national level is acceptable. Nigeria has many of the right *national* policies and conventions in place, even if many require updating or more comprehensive plans. Political will is another issue, however. There are, by contrast, outstanding financing and policy issues at the state and LGA level that impact child survival programs.

As it moves toward an integrated strategy, USAID needs to further focus its "policy agenda," especially given human resource constraints. **Current national level activities remain important, but little by little policy activities should devolve to focus states and LGAs where they directly impact on service delivery.**

4. Private Sector: Nigeria's private sector is broad, complex, dynamic and huge. It includes everything from tiny local PVOs to huge multinational corporations doing billions of dollars worth of business. Market forces are particularly vibrant in Nigeria, a fact reflected in the health sector.

The vast majority of poor Nigerians obtain medicines through small patent medicine vendors (PMVs) and local health workers, and a significant percentage of health care, especially in urban areas, is provided through private sector hospitals and clinics. Quality is a big issue from drug supply (fake drugs) to clinical quality of care and infection prevention (universal precautions to protect against transmission of HIV). Community (PMVs, midwives, etc.) and mid level (community clinics and hospitals) practitioners do not have easy access to the latest technologies and treatment protocols

in public health areas. An important advantage of donor-supported commercial or social marketing efforts (such as NetMark and the Society for Family Health) is their commitment to passing sound technical information through commercial channels.

In the benevolent sector, there are huge numbers of local and international NGOs, private foundations and other charitable. Private health providers and Non-Government Organizations (NGOs) contribute significantly in PHC and other CS activities in Nigeria.

5. Integration: Child survival programs and their results could benefit immensely from integration with other USAID programs, including those in – Agriculture, Water and Sanitation, Education and other sectors. Although some effort is already directed at such integration, additional consideration is warranted.

C. USAID COMPARATIVE ADVANTAGES

Based on the findings noted above and on discussions with a variety of stakeholders, the team identified a number of areas in which USAID/Nigeria holds important comparative advantages. These were further weighed and considered by the team in the formulation of recommendations. USAID's comparative advantages lie in:

Technical Assistance – USAID is a recognized leader in state-of-the-art technologies in all health areas.

- Advocacy – This is an area of historical strength of US assistance programs. As a major donor and super power, USAID influence on policy is significant.
- Flexibility – USAID and its partners have demonstrated a remarkable degree of responsiveness to changing needs and conditions.
- Ability and Experience working in the NGO and Private Sectors and Community level approaches – Unlike most donors, USAID has always supported a wide variety of private sector initiatives in Nigeria; and it remains one of the few donors to actually reach the grass roots level effectively.
- Behavior Change and Communication – USAID and its partners have evolved systematic and evidence-based approaches to changing health behavior and community norms on health issues.
- Results-based approach – USAID pioneered among international donors in putting into practice a strong, data-driven system to "manage for results." Results-based approaches are important to orient programs and define success.

D. RECOMMENDATIONS

Nigeria is large and complex, and its child health problems seem intractable. Although incremental gains are being made in some areas and there are a number of promising programmatic approaches, overall, the survival of Nigerian children depends more on internal geopolitical and social reform than on anything a donor can fund. When queried, many Nigerian informants spoke movingly of their hope - and prayer - that the "way forward" for Nigerian children lies in growing Nigeria's democracy and curbing corruption.

Nigerian informants and other stakeholders provided many sound recommendations, which the team validated and distilled into broad strategic recommendations. They are discussed in detail in the final section of this report.

General

- **Integrate:** Integration as a principle is a positive force for efficiency and effectiveness. At the service delivery level, all programs should be integrated.

- **Tighten policy and research agendas:** Clear mechanisms are needed for USAID to develop and update a highly focused policy and research agenda with mechanisms to exclude issues or research that is marginal to central issues.
- **Develop an integrated BCC approach:** USAID and its partners must evolve a behavior change and communication strategy that is comprehensive, evidence-based, culturally sensitive and focused on outcomes across sectors, rather than a knowledge-based, sector specific approach.
- **Expand public-private partnerships:** The private sector offers a crucial link to populations and a "safety net" in case public sector programs fall short. Whenever possible, child survival should be integrated as part and parcel of private sector efforts.
- **Design evidence-based and data driven programs:** Carefully set performance targets, programmatic benchmarks and monitoring and evaluation protocols are essential to the new USAID strategy. They must pass very strict and "achieve-ability" criteria, with levels of funding taken into account.

Program Areas

- **Malaria:** Malaria remains the first killer of children in Nigeria and should remain a priority for USAID, consistent with the three major RBM areas.
- **Immunization:** USAID should focus on routine immunization and leverage other programs and donors to strengthen routine immunization. Ensure that private sector vaccination capacity is developed as back up to the public sector.
- **Nutrition:** There is a need to adopt a more rational and holistic approach around key behaviors with proven impact on child health.
- **Other child survival interventions:** USAID should seek opportunities to reinforce and support ongoing programs in ORT, ARI, IMCI with non-costly interventions (e.g. including them in a BCC strategy, reinvigorating ORT corners, include them in curriculum updates).

Recommendations for the Transition Period

- **Strengthen health care financing knowledge:** Additional information gathering and analysis is necessary in this area. Work with World bank
- **Inventory/annotate policies, norms, "Standing Orders" and curricula:** A team should be organized to conduct an across the board inventory and technical review of all "guidance" materials being used in public sector health programs. Discus with PHCDA
- **Inventory, integrate and innovate in BCC:** BCC for child survival in Nigeria needs an injection of enthusiasm and innovation and a strong strategic perspective based on sound behavior change theory and well defined messages. External technical assistance for this should be sought. JHU to lead the way
- **Harmonize and energize community approaches:** A small working group composed of experienced community mobilization experts and strategic thinkers should be formed to identify common approaches and problems and help harmonize models. Same as bullet 2
- **Cross-train IP staff in CS, RH and HIV/AIDS SOTA technology:** This will be necessary to move into an integrated mode for programming and technical support, particularly at the community level. Quaaaaaa;ified staff should be hired by IPs
- **Analyze vaccine and essential drug capacity:** USAID needs to determine whether there are points within the supply system where targeted interventions would be helpful. Very critical
- **Link research with policy and performance indicators:** USAID should encourage links between policy and research, maximize research links to programs and re-think the role of applied and operations research across the health/education sector. ARCH to be reengineered

Four Urgent Needs

- Address the issue of Taxes and Tariffs on nets, yarn and insecticide for ITNs. Be on the "look out" for similar issues in upcoming plans for food fortificants. Ongoing
- Address the problem of **vaccine stock-outs,** initially and urgently in the LGAs where BASICS and other IP's operate. "No Product, No Program!"
- Follow on the launching of the National Nutrition Policy with a Plan of Action. Insure multi-stakeholder involvement and integration of Food Security and a rational approach to "Essential Nutrition Actions". Ongoing
- Given the effect of HIV/AIDS on the nutritional status and health of entire households, USAID/Nigeria should be actively engaged with government and partners in Nigeria to develop comprehensive HIV/AIDS care and support guidelines to ensure that programs recognize and provide support to these vulnerable households. This would include directing Title II assistance to vulnerable households (potentially identified by food deficits/insecurity rather than by HIV-infected individuals if stigma is an issue).

I. OVERVIEW OF CHILD SURVIVAL IN NIGERIA

> *What we are doing for our children, we are doing for ourselves and our future.*
> Masalaha CD Association Leader
> Kano State CAPA Member

A. BACKGROUND:

Lying on the West Coast of Africa, and with a total surface area of 923,708 square kilometers, Nigeria is divided into six geo-political zones (for administrative and political convenience) and has a total of 36 states, a Federal Capital Territory and 774 Local Government Areas. The country is operating a young multi-party democracy – a presidential system of government comprised of elected Executive President, the Legislature and a Judiciary at the national level; and similar officials at the state and LGA levels. Nigeria has an estimated population of 120 million and a population density of 128persons /sq. km. The population is pyramidal: 45% children below the age of 5 years, which implies a high dependency ratio.

Although the rate of urbanization is rising, more than **60% of the population still lives in rural areas**, **dependent on subsistence farming, especially in the northern parts of the country. Although the major** industry in Nigeria is agriculture, about 90% of foreign exchange earnings is derived from oil. With fluctuating oil prices worldwide, it is little wonder that the structural adjustment program introduced in the 1980's to correct economic imbalances had a serious negative impact on the socio – economic standards of Nigerians and on the quality and utilization of health services.

> *Lagos is bigger than most African countries in terms of population, complexity and density.*
> Honorable Commissioner for Health
> Lagos State

Nigeria is a multi-cultural, multi-ethnic and multi-religious society**,** with more than 350 ethnic groups and three large religious groups. There is enormous competition between groups for access to the nation's resources. This multiplicity of groups implies a complex mix of cultural practices that impact health. A glaring example is the effect certain methods of food preparation (e.g., over cooking of vegetables which is common among many groups) have on nutrition. Additionally, in some rural communities food taboos lead to the withholding of eggs, chicken and meat from children in the belief that this will prevent them from stealing when they become adults. This, combined with the cultural practice of discarding of colostrum and the consequent delay in the initiating breast feeding can have serious effects on nutritional and health status in early childhood.

Other cultural practices that affect child survival and maternal health include early marriage and female circumcision, both of which could be underlying causes of obstructed labor, abortion, and hemorrhage leading to high rates of maternal mortality. The following socio-cultural factors contribute immensely to CS status in Nigeria, and require attention and amelioration:

- Female Genital Mutilation (FGM), practiced in the first year of life and on the pregnant women at delivery;
- Gender differentiation in child raising and socialization;
- Increasing involvement of women in the labor force without the corresponding capacity and options for child minding;
- Limited involvement of fathers in raising children;
- Low levels of exclusive breast feeding;
- Sexual exploitation and trafficking in women for commercial sex work; and
- Child marriage affecting girls.

Nigeria has a rapidly growing population with rapid urbanization driven by excessive pressures on land resources, poor infrastructure and limited employment opportunities in rural areas; and the continuous creation of new state and Local Government Area (LGA) headquarters. These forces individually and collectively encourage rural-urban migration. The sudden influx of large numbers of people into new urban centers increases demand on existing social services. As a result, basic services are overburdened. Overcrowding and squalor are characteristic of Nigerian cities. This, in turn, facilitates the spread of communicable diseases, and the vicious cycle of malnutrition and infection ensues among young children.

More than 80% of the population of Nigeria is considered poor, while 25% of the nation's wealth is owned by 5% of the population. Such a situation leads to further deterioration of the health status of the majority of the people.

Illiteracy is very high; more than half of the adult population is illiterate (females 59%, and males 41%). Consequently, women have fewer employment opportunities than men. The high level of illiteracy in women has a negative effect on maternal health and CS. With few exceptions, evidence suggests that the better educated exhibit better health seeking behaviors than the uneducated and the latter are less likely to be able to afford treatment for severe illnesses. Similarly, the rate of under-five mortality is higher among children whose mothers are illiterate.

The Maternal Mortality Ratio (MMR) of Nigeria is one of the highest in the world at 704/100,000 live births. Zonal variations of the MMR are large, with the North East having the highest (1549/100,000) and the South West the lowest (165 / 100,000 live births). Other noteworthy health indices for the country are seen in the table below. More details on child health indices are found in Annex C.

Crude Death Rate	43 / 1,000
Crude Birth Rate	16 / 1,000
Infant Mortality Rate	114 / 1,000 live births
Under Five Mortality Rate	239 / 100,000 live births
Low birth weight	17%
Under Five Malnutrition	45%
Complete Immunization before 1st birth day	13%

Source: the status of PHC in Nigeria, NPHCDA, May 2001

The continuous loss of the extended family system with its valuable features as a "social safety net" has led to an escalation of social insecurity and poverty. The traditional sense of mutual obligation toward family members' total welfare is fast disappearing, leaving the weak or chronically ill without guaranteed support to face hardships and an inability to meet their basic needs.

The rapid spread and rising prevalence of HIV/AIDS and its impact on the economy and the health status of children and their parents is exacerbating social insecurity and poverty. Fifteen years of military rule nurtured large-scale erosion of the social and moral fabric of Nigeria, resulting in the frequent incidence of economic sabotage, nepotism and corruption even at high levels. Consequently, there is rising unemployment (of the youth in particular), great frustration and despair. Conflicts and clashes abound.

Nigerian children are affected by very high levels of mortality and morbidity from diseases that are preventable with simple and affordable measures. Over 90% morbidity and 80% of mortality in children under five years of age come from four causes: malaria, Vaccine Preventable Diseases (VPD), diarrheal diseases and acute respiratory infection. These account for 30%,22%,19% and 16% respectively of under-five deaths. Among the vaccine preventable diseases are pertussis (6%),cerebrospinal meningitis (6%), neonatal tetanus (5%) and measles (5%). Nigeria is one of the five remaining global polio reservoirs. A total of 57 polio cases were reported in 2001, and 142 cases (over 200) in 2002 (as of October, December
).
Malaria accounts for 30% of under-5 deaths and 11% of maternal deaths. There is a high prevalence of diarrheal disease among children (estimated at 15.5% - NDHS 1999). The prevalence of Acute Respiratory Infection in children is 11% (NDHS, 1999). This is combined with high levels of malnutrition and micronutrient deficiency, worsening the health status and development potential of Nigerian children. An emerging threat to young children is HIV/AIDS, which can be transmitted from an infected mother to her child in the womb, at the time of delivery or through breast milk.

B. GOVERNMENT RESPONSE

Nigeria has responded to the poor health situation of its people by putting in place an enabling environment for the actualization of International Conventions and agreements. In this regard, the Nigerian government has signed and ratified a number of United Nations and regional charters and conventions responding to the rights and welfare of women and children, including:

- Convention on the Rights of the Child
- Organization of African Unity (OAU) Charter on the Rights and Welfare of the Child
- Declaration and Plan of Action for Children (from the World Summit on Children)
- Convention on the Elimination of Discrimination Against Women (CEDAW)

- Preparation of the National Plan of Action (NPOA) for the Survival Protection and Development of Children (adopted in 1992)
- Formulation of a broad National Health Policy, with Primary Health Care as its cornerstone and main focus
- Formulation and operation of certain CS-specific internal policies such as those on Breast Feeding, Immunization policy and Standard of Practice, Essential Drugs, Population and Sustainable Development, Fortification of Food with Vitamin A, Reproductive Health, Nutrition, MCH, Malaria Control Policy and ITN and Water Supply and Sanitation Policy. An all-embracing Child Policy also was drafted and approved recently
- The formulation and implementation of CS programs such as IMCI (Integrated Management of Childhood Illness), BFHI (Baby Friendly Hospital Initiative), RBM (Roll Back Malaria), Nutrition, the control of HIV/AIDS, prevention of Mother-to-Child Transmission (MTCT) projects
- Decentralization of program management and operation through the establishment of semi-autonomous agencies such as: 1) NPI Agency (National Program on Immunization), 2) National PHC Development Agency, 3) NACA, 4) National Agency for Food, Drug Administration and Control
- The reorganization of health departments at the LGA level into MCH, Immunization &Disease Control, Health Education and Women Activities and Supplies and Essential Drugs

Other responses address poverty reduction, provision of basic education, water and sanitation, protection of the environment, enhancement of food production and security, etc. Attempts have been made to coordinate donor support through the National Planning Commission and the formation of the Immunization Coordinating Committee (ICC). A number of state and local governments have declared their resolve to provide free health care to special groups such as women and school children, either for political reasons or as a measure to cushion the burden of poverty afflicting their citizenry.

> *The previously high gains in immunization coverage were 'donor driven.' The key to sustainability is local and state resource generation and commitment.*
>
> WHO Representative Nigeria

The Federal Ministry of Health, supported by DFID, the World Bank and African Development Bank (ADB), is embarking on health sector reforms with a view to improving the financing of health care in the country. In addition, the World Bank supports state government reforms with the "Health Systems Funds." The NPHCDA also is piloting a community-based model for implementation of Primary Health Care, which could complement or accommodate the USAID/BASICS CAPA model in 200 LGAs.

C. ANALYTICAL FRAMEWORK

In order to systematize its assessment, analysis, and recommendations, the team developed a framework during the course of the assessment visit (figure 1). This framework was useful in identifying key levels and types of action for USAID investment of resources and efforts. It is also compatible with the operational framework developed by UNICEF, one of USAID's major partners in child survival, and captures several elements of USAID's Strategic Objective framework. The elements of the framework are as follows:

1. Outcomes - Three general categories of outcome are defined:

- **Enabling Environment.** Actions to create conditions for increased availability of resources, coverage, or effectiveness of one or more child health and nutrition interventions. Examples include advocacy, development of improved policies, and establishment of conditions for increased availability of commodities, and approaches that increase resources through either public or private channels. While actions at the most central levels (national and even international) are often in this category, important actions to improve the enabling environment can happen at all levels, including the community level.

- **Capacity Building.** Activities and inputs to strengthen the ability of those charged with providing child health and nutrition services, whether care of sick children or promotion of behavior change, to do so more effectively. These activities and inputs may include the traditional approaches of building knowledge and skills of providers (in the public or private sector). However, other important actions may have equal or greater effect, such as improved availability and use drugs and vaccines, improved use of information for management and decision-making, and operations research to develop more effective approaches to deliver services or promote behavioral change. Investments in this category of outcome can be made at several levels, from the central (national) level, to states and LGAs, to local providers of child health and nutrition services and information. They may also be made in either the public sector, the private sector, or both. This category of outcome largely corresponds to the "supply" side of child health and nutrition interventions.

- **Promoting Healthy Practices.** These are defined as activities and inputs that increase appropriate use of child health interventions by communities and families. This category may include such activities as organization and mobilization of communities (or of existing organizations within communities), investments in knowledge generation, behavior change and communication, and actions to remove constraints or promote utilization of interventions. Many actions in this category of outcome are targeted to the household and/or community level. However, important actions in this category also include media-based strategies to promote behavior change or large-scale planning for social mobilization. This category of outcome largely corresponds to the "demand" side of child health and nutrition interventions. Ongoing

2. Cross-Cutting Support – This part of the framework encompasses areas of investment affecting several child survival or PHN program areas. They included areas such as logistics management, monitoring and evaluation, behavior change/communication, and public-private interaction. USAID frequently has significant technical expertise and comparative advantage in these cross cutting areas. When adequately tied to outcomes, they are potentially important areas of investment.

3. Level of Action and Responsibility – This is a key factor to be taken into account when considering the USAID investment strategy. As noted, many desired outcomes need to be addressed at more than one level. However, both in terms of strategy and of most effective use of scarce resources, USAID will need to find the most appropriate levels to make its investments, balancing overall impact with other considerations, such as geopolitical commitments or opportunities to leverage resources. Levels identified in the framework include:

- ***International.*** This level includes activities such as bringing state-of-the-art (SOTA) technical knowledge to Nigerian policy and programming, working on Nigeria-specific issues at the international level with investors such as GAVI, GAIN, and Roll Back Malaria, and identifying opportunities in Nigeria to carry out applied research that has international importance.

USAID/Nigeria may rely on USAID/Washington and its central cooperating agencies to carry out these activities, with defined feedback and coordination mechanisms.

- ***National.*** Actions at this level include interactions with the Federal Government of Nigeria and with the national headquarters levels of other organizations working in child survival (e.g. UNICEF, WHO, World Bank) Examples include active, high level USAID participation in such bodies as the GAVI Inter-Agency Coordinating Committee (ICC), and participation in critical policy dialogue on issues such as tariffs on importation of impregnated bednets, as well as support in development of national norms and standards of practice. This level also includes private sector-oriented actions with organizations having national (or multi-state) reach, such as distributors of bed nets, large scale food producers capable of undertaking food fortification, or social marketing of child health related commodities or information.

- ***State.*** USAID is committed to having a focused presence in selected states. States play a major role in health care, but their roles have not been clearly defined or agreed upon in some areas, particularly implementing basic PHC services. Inputs at this level will likely be a critical element of an overall CS strategy. In the public sector, investments may include support for improved management functions (such as planning and logistics), capacity building, and development and implementation of effective program approaches (including operations research). There are potentially important opportunities for "enabling environment" investment at this level as well, such as revitalization of the "State Health Councils," whose role is meant to be the development and monitoring of approaches to implement national policies in the health sector. In addition, many partners, (WHO, UNICEF, IP's such as BASICS) have established operating units at the state level, opening up opportunities for partnership. Important private sector activities may also be most effectively carried out at this level, including work with producers, suppliers, and marketers, as well as with larger NGOs.

- ***Local.*** The local level is the key place where supply meets demand. It is the focus of actual implementation of programs and delivery of services and the point at which health system management comes closest to communities and individuals. It is the level where the private sector tailors its services to the community. Important actions related to improving the availability, capacity, quality and management of services and information can be supported at this level. Thus, this level is likely to be an important focus of some USAID investments in health. Since there are 774 LGAs in Nigeria, USAID must seek ways to affect LGA-level outcomes at a meaningful scale.

- ***Community.*** Community level action is an essential component of virtually all current USAID program partners. In view of huge challenges in local health services, community organization and action provides critical support in promoting both household level actions such as breastfeeding and bednet use, and utilization of appropriate services, from immunization to sick child care. Examples of interventions at this level include community organization, use of community channels to provide information, and improved availability of and demand for commodities. Community mobilization is effective in increasing availability and quality of appropriate services through trained community agents (such as CBD workers) or private sector providers (such as patent medicine vendors, who are frequently sought for treatment of child illness). It is important for USAID to find ways to invest in community level approaches that can reach a meaningful scale.

4. Activities and Interventions – Figure 1 provides examples of activities that might be carried out at each level of the framework, as well as examples of programming approaches

to intervention, using malaria as an example.

5. Synergies and Integration - The framework provides for the identification of synergies and opportunities for integration of different actions and program interventions, relating them to the three major categories of outcome and the different levels of the system. Identification of these areas of synergy and integration allowed the team to envision and recommend options for integrated programming by USAID/Nigeria.

II. THE USAID/NIGERIA RESPONSE

USAID has been involved in child survival in NIGERIA since the early 1990's. During the years of military rule, USAID maintained a presence in Nigeria, working through the private sector, at a reduced scale and funding levels. The BASICS Project worked through an indigenous NGO Network called Community Partners for Health to help communities come together to address their own health issues and create partnerships. The CPH's proved that communities could be successfully mobilized to help themselves in times of crisis. Many of these communities also developed working partnership with International Partners working in reproductive health.

Within months of the transition to a democratic government, the USAID portfolio began to grow dramatically. In October 1999, USAID/Nigeria launched a four-year transition strategy, working in health, education, agriculture, and democracy and governance. The Population/Health/Nutrition Unit has three sub-sectors: child survival, population/family planning and HIV/AIDS. Currently these sub-sectors are managed separately, although considerable effort is being made to foster integration and collaboration.

In the absence of a bilateral agreement with the Nigeria Government, USAID has in the past obligated money through US-based International Partners. While appropriate in its time, USAID/Nigeria now views this arrangements as too management intensive and as reducing their flexibility. Under the new strategy, USAID will obligate funds through fewer, larger. This analytic agenda to inform its new five-year statedy. Companion assessments were done in HIV/AIDS and population reproductive health and will be done in education and Food Security.

Currently, the BASICS Project is the principal IP working in the sector. BASICS staff inputs over a broad range of technical issues and with the NPI on polio NIDs. BASICS works at the community level in three states. JHU/CCP is tasked with behavior change communication for child survival, N-ARCH with applied research, IITA on food supplementation and a National Nutrition Survey, NetMARK on commercial marketing of ITNs, and The Policy Project on policy issues. A summary of each IP's area of intervention is Annex D.

In addition to the activities of IP's, the USAID team has considerable "hands on" involvement in a variety of policy and implementation areas. For example, they are active members of the ICC, USAID helped negotiate the launch of the National Nutrition Policy, and they sit on a variety of coordination committees. The small Child Survival Unit in USAID/Nigeria carries a large burden of supervision and direct policy intervention.

In the future, USAID proposes a strategy that will integrate the health and education sectors. HIV/AIDS will receive the largest portion of funding under the new strategy (and be managed under its own Strategic Objective), followed by population/family planning. Activities in both education and child survival will be subject to resource constraints. It is in this context that the team undertook its

analysis. Given the magnitude of the child survival issues Nigeria faces, every dollar must be leveraged and/or used to its maximum potential.

III. ASSESSMENT FINDINGS IN TECHNICAL PROGRAM AREAS

A. MALARIA

The Roll Back Malaria (RBM) movement in Africa has defined three key strategic interventions reflected in the three Abuja Summit targets: prompt and effective treatment of malaria illness in children under five; access to and use of insecticide-treated nets (ITNs); and intermittent preventive treatment (IPT) in pregnancy. The RBM partnership in Nigeria has drafted a strategic plan that includes these major strategies as well as others. The status and strength of progress in implementation of each varies. The partnership itself in Nigeria is erratic and only somewhat effective in mobilizing sustained high-level commitment, coordinated inputs and strategic technical direction. The major partners in Nigeria have been WHO (with three NPOs assigned to RBM), UNICEF (which has taken a leadership role in ITNs), the World Bank (which remains a somewhat distant but important voice in the partnership), DFID and USAID. There does not appear to be consistent strategic input from either NGOs or the commercial sector except through the NetMARK mechanism. The RBM Committee seems to lack skills and direction for advocacy.

Although malaria represents a significant portion of the USAID child survival funding and program, the mission does not seem to have maintained strong attention to the RBM partnership and strategy. Aside from sizeable investment in NetMark, which as yet has no local program officer to facilitate liaison with commercial and other partners, USAID malaria funding and programs are fragmented. USAID is represented in the RBM partnership variably by mission staff, by local IP staff (BASICS, Policy), or even from regional IP staff (NetMark). Some relevant IPs do not seem to be part of the formal RBM partnership (ARCH, JHU). This diffuse USAID attention reinforces the weakness in the national RBM partnership.

The implementation of ITNs is probably the most well developed of the three RBM interventions, and a broad strategy consistent with regional guidance from RBM has been agreed to by partners in Nigeria. President Obasanjo moved quickly to reduce taxes and tariffs on nets and insecticides after the Abuja summit in April 2000, enabling the RBM partnership to fully embrace the expansion of the commercial sector in provision of ITNs in Nigeria. Both DfID and USAID have made significant investments in public-private partnerships for ITNs, USAID through the NetMark project. UNICEF has provided initial inputs at community level to stimulate demand through CBOs. UNICEF also established and maintains a partners' forum for coordination of ITN activities throughout Nigeria. However, recent events have revealed the overall weakness in the RBM partnership: a reimposition of extremely high taxes and tariffs on nets and insecticide, although apparently a bureaucratic oversight rather than willful action, threatens all of the progress to date, particularly the continued viability of NetMark. Yet USAID and the partnership have been unable to effectively mobilize high-level attention from the FMOH or the Ministry of Finance to correct the situation. Time is running out as elections approach.

FMOH has been sluggish in its support for commercial ITN distribution, preferring to rely on donors to support free distribution of ITNs. A weak RBM committee with a rotating leadership has been unable to push for a sustainable multi-channel approach. The IMPAC scheme to offer free nets as a reward for ANC attendance has not moved forward, the FMOH unable to move the nets (100,000 provided by UNICEF) out of the warehouse.

Nigerian net manufacture is able to supply perhaps 1.5 million of the 15 million nets needed annually in the country. NetMark approached these manufacturers but found none producing nets of sufficient quality to be marketed under the NetMark logo. NetMark offered technical assistance to the manufacturers to improve quality. There is no local manufacture of insecticides for ITN treatment. The greatly increased demand creation activities of NetMark and others have produced a response in the local market and locally produced nets are being packaged with treatment kits and marketed as ITNs.

Similarly, local drug manufacturers have been quick to respond and capitalize on RBM communication about treatment and efficacy. Local products are packaged and marketed to address concerns about resistance. However, the problem of poor quality and counterfeit drugs, including antimalarials, is acute in Nigeria (and thereby in neighboring countries as well). There is no coherent RBM strategy either locally or in the region to address this issue.

The RBM strategy for implementation of early and effective treatment in Nigeria, an area in which WHO has taken on but not exerted leadership, has moved much more slowly. There was early commitment to unit dose pre-packs of antimalarial drugs and some elements of the pharmaceutical industry in Nigeria have responded by producing color-coded blister packs. It is unclear how these packs are to be deployed. The design and planned deployment of the pre-packs was not informed by available research (funded by USAID through TDR). Pre-packed doses are expected to make it easier for mothers to identify appropriate drugs in the market, which is swamped by hundreds of brands, formulations and presentations of antimalarial drugs, both real and fake.

A more fundamental problem, however, is the long-standing question of the therapeutic efficacy of chloroquine. WHO has recently supported Nigeria in the re-establishment of sentinel sites for surveillance of drug resistance (sites originally set up with USAID/CDC support in the 1980s). Data have been collected, but policy discussions and decisions about effective first-line treatment policy revision have not begun. Until such decisions are made, it is unlikely that any strategy for bringing effective treatment closer to families and communities will be successful in reducing malaria morbidity and mortality in young children.

It has been well documented that most treatment of febrile illness in young Nigerian children takes places outside the formal health system. It is equally well documented that a large portion of antimalarial drugs available for community use is of extremely poor quality. The majority of febrile children in Nigeria are not given treatment that can prevent progress to severe illness or reduce the anemia that results from chronic parasitemia. The RBM strategy in Nigeria of pre-packed drugs could improve this situation with a coherent strategy to link demand for effective treatment with supplies of the appropriate drugs in communities; in effect, a strategy to work with the private sector.

Policy development and formulation in Nigeria appears to be largely donor-driven with much external TA and Nigerian academic research input but with little insight or buy-in from State and LGA levels. Policy documents and decisions appear not to penetrate in any useful way to implementation. This was clearly shown in the initial RBM situational analysis in Nigeria; LGAs were unaware of malaria policies.

The RBM strategy for Nigeria also includes IPT in pregnancy. However, the policy has not been promulgated; does not seem consistent with standards laid out in the Regional Framework for Control of Malaria in Pregnancy; has no clear relationship to policies and programs of reproductive health in

the FMOH; and is implemented nowhere in the country. Nigeria is a focus country for WHO's Making Pregnancy Safer Initiative, which includes IPT. This is an opportunity for coherent implementation of IPT and integration of USAID's RH and CS programs.

The capacity for direction and management of malaria control efforts in FMOH suffers from many of the same weaknesses as any other program. Key aspects of what should be a coherent program are scattered throughout the FMOH. Natural programmatic partnerships with IMCI, RH and PHC within FMOH are not fostered. Cross-sectoral partnerships are not sustained. Leadership for malaria in the FMOH is sparse and often out of the country attending meetings.

The FMOH malaria program is supported almost exclusively by WHO. There is a disproportionate emphasis in the program on training, research and materials production. As the mechanisms for coordinated action—the RBM partners' forum—is weak, actions are often untimely and unconnected to strategy or plans. Despite commitments to increase government investment in health and in malaria made at the Abuja Summit, the program suffers from the acute lack of funds that afflicts other health programs in Nigeria.

At the state level there is often a request to build malaria technical teams, which are believed necessary to provide technical guidance and oversight: epidemiological, entomological, clinical, etc. This is not a sound strategic plan for tackling malaria at the state level. The balance of technical competence, management skill, quality assurance and partnership development needed by the States should be carefully considered. The development of broad competence in malaria cadres at this level will not likely be an element of USAID programming. However, targeted inputs to RBM partners' discussions of capacity building, particularly the World Bank and DFID, could build on USAID's comparative advantage and access to CDC, US schools of public health, and technical projects. A Nigeria needs assessment organized by partners in the wider context of global RBM plans for capacity strengthening for malaria could clarify the appropriate balance of competencies to strengthen state level action.

At LGA and community levels, the competencies and capacity needed for malaria control are much the same as for immunization or nutrition: mobilization of communities and resources, management, supervision and quality, monitoring and communications. However, the importance of the private sector (both NGO and commercial) in ITN and treatment interventions highlights an additional necessary capacity—effective work with retailers and commercial agents. At present, communities are mobilized to link with public sector facilities and supplies; malaria interventions will require community links to national and state ITN and treatment delivery schemes in the private sector.

One exception is the delivery of IPT as part of an integrated antenatal package. This is a new intervention to be delivered through facility-based ANC. Introduction and strengthening of this intervention will require all of the foundational processes: formulation of policy and clear guidelines and standards; integration into pre-service and in-service training; development of job aids and communication materials; regulatory, procurement and logistics actions to provide supplies; communication and behavior change to introduce IPT to women and communities. None of this has begun. USAID has a distinct advantage in the RBM partnership to move this interventions forward; USAID and its malaria and RH partners (CDC, MNH, RPM+) have been key players in the development of the Regional Framework with WHO and UNICEF. USAID and its partners also play a major role in the multi-country sharing of experience, tools and strategies for scaling up IPT in both East and West Africa. This experience could be brought to IPT in Nigeria. (see Annex on MAC below)

The key behaviors for malaria are well-articulated in the region as part of both RBM and IMCI: recognition of febrile illness and rapid administration of an adequate dose of an effective antimalarial drug; recognition of severe illness and rapid referral; regular and proper use of ITNs; early attendance at ANC and use of IPT. Other related behaviors (continued feeding, etc) are also clearly defined. It is not clear how far community IMCI has moved in Nigeria. BASICS is only now beginning to include malaria in its community activities. Those partners engaged in malaria control at community level in Nigeria (e.g. BASICS, UNICEF) appear to focus on recognition and treatment and ITN use, as those are the only present interventions available. However, behavior change communications for malaria must be supported by the availability of commodities—ITNs and effective, accessible treatment. For ITNs there is as yet no direct linkage of community efforts to the top-down marketing and market expansion efforts of NetMark.

NetMark has initially targeted six states, including Lagos, Kano and Abia States, where BASICS has been active in communities. Next year NetMark will expand coverage to another 12 states. However, the expansion of the retail availability of ITNs through NetMark moves slowly: retail outlets have grown to over 200 from an initial 20 when the project launched in Spring 2002. **At present, the demand that has been generated by intense marketing in the 6 states must refer to Lagos for information on retail outlets. AWKWARD – I DON'T KNOW WHAT THIS MEANS).** Solid links to the existing CAPAs in three states could focus the demand locally and "grow" the market nearer to community demand. The scope of the NetMark Project has been expanded to enable such innovative partnerships with UNICEF, communities and RBM partners. Encouragement of this link at community and LGA levels is critical. A similar link between RH activities at community level and PSI national demand creation has occurred.

BASICS is developing materials and messages for use at the community level. This is still a fairly new effort in the BASICS program. The messages are not yet focussed on the key behaviors. The materials and methods are still limited to generic information about ITNs and dosing schedules for chloroquine, etc. There are not yet activated or linked messages that improve access to NetMark nets or retailers; that guide communities to better quality drugs and treatment choices; that mobilize communities to demand improved services and provision in the private sector. There is no apparent attempt to assist communities in identifying those at risk (biologically and economically) or work toward ITN coverage or treatment. ITN use is a new behavior that needs to be introduced. Treatment comprises a set of behaviors by mothers and providers that needs to be radically improved. Strategies to accomplish these two very different tasks may also be differently conceived.

Patent medicine vendors, a major source of treatment for fever in the community, have not yet been formally linked to malaria activities. PMVs were part of CPH in Kano State where more formal private practitioners and facilities are rare, unlike Abia and Lagos. It was hoped that PMVs could work in a triad of facility, CBO and PMV. This did not occur as a PMV is not comparable to a health facility. But the PMV association eventually did become a CBO member and PMVs were elected to CPH boards. PMVs were trained and established ORT corners. Later, PMVs came to play a role in CEDPA FP commodity access.

There is no apparent activation of antenatal IPT at community level. This may result from the lack of a clearly documented national policy as well as limited availability of the necessary drugs.

Community-level activities are also carried out by the agriculture and education sectors of USAID. There appears to be no overlap between these and malaria activities, although there are several

potential areas for sensible integration. Malaria has a clear and significant impact on the agricultural sector. Farmers recognize the impact on production and family welfare, no so much from their own illness, but from that of their children for whom they must care, and whose care is a drain on family income and assets. Integration of agricultural and health programs, perhaps most clearly in the realm of micro-financing and household economy, should be explored. Integration of basic education and malaria activities is not as clear. Treatment of malaria in schools sounds good but is a low priority; school children are not at high risk for malaria morbidity and mortality in Nigeria, and it is not proven that health messages in school lead to improved behaviors in later years or influence family decisions in the present.

The current malaria-relevant indicators reported by the mission and its IPs are only partially consistent with RBM and USAID indicators. There is a DHS planned for early 2003 that will include the malaria module and provide a standard baseline for future program M&E. However, a review of the current plans for data collection and reporting by IPs and communities would strengthen the mission's ability to report results for this significant part of its health portfolio.

B. NUTRITION

While Nigeria has the potential to produce sufficient food to meet the needs of its population (~130 m) and for export, food production deficits over the past decade have led to widespread food insecurity and malnutrition, especially among women and young children. On average, households expend more than 75% of their income for food, and in most households that food fails to meet minimum dietary requirements for energy, protein and micronutrients. Malnutrition is further exacerbated by the high burden of infections, lack of safe water and sanitation, inappropriate household dietary and health behaviors, and the effect on women of too frequent child bearing beginning too early in life.

Fully a third of Nigerian children are stunted. Growth retardation begins before birth (LBW rate ~15-20%) and becomes more severe over the first two years of life due to poor breast feeding and complementary feeding practices (delayed initiation and nonexclusive breastfeeding over the first six months; poor quality and infrequent feeding of complementary foods), aggravated by frequent and severe childhood illness.

Rates of anemia among women and young children remain high, largely due to micronutrient deficiencies (iron, vitamin A, folate, B6, B12), infections (malaria, helminths, HIV/AIDS) and genetic factors (sickle cell). While reliable vitamin A deficiency (VAD) prevalence data await the results of the 2001 National Food Consumption and Nutrition Survey (IITA, USAID, USDA, FGON, UNICEF – initial results to be released in January 2003), VAD is expected to be severe among under-five children. The only significant nutrition success story in Nigeria over the past decade has been the achievement of virtually universal iodization of household salt (98%), resulting in dramatically improved iodine status across the population.

A 15-year (2002 – 2016) National Policy on Food and Nutrition in Nigeria, drafted in 1995 and approved in 1998, was officially launched by the National Planning Commission on November 5, 2002.

Seven priority nutrition "actions" are identified in the policy:
Protect, promote, and support optimal child feeding practices in the first two years of life.

1) Ensure that the iodine requirements of the population are met.
2) Ensure that the iron and folate requirements of the population are met.

3) Ensure that the vitamin A requirements of the population are met.
4) Ensure adequate nutritional support for adolescent girls, pregnant women and lactating mothers.
5) Ensure adequate nutritional care and support for people living with HIV/AIDS.
6) Ensure the prevention and control of nutrition-related non-communicable diseases.

Although the policy is comprehensive, and it was a prelude to drafting a more strategic action plan. The National Plan of Action for Nutrition will be drafted under the direction of the National Committee for Food and Nutrition (NCFN), an interministerial committee for nutrition policy formulation and program coordination within NPC. While the NCFN seems prepared to move forward immediately with drafting the plan of action, there is a need to draw on a full analysis of the data from the National Food Consumption and Nutrition Survey and engage key partners in making strategic decisions about program priorities, phasing, roles and responsibilities that will make the national plan implementable and supportable by all partners (government at all levels, private sector, bilateral donors, multilateral agencies, and foundations and trusts).

Vitamin A Supplementation

While there is a tendency to project a similar reduction in child mortality (23%) by routine Vitamin A supplementation across the board in countries where Vitamin A deficiency is prevalent (>20%), vitamin A will almost certainly have greater impact in countries where (1) less than 20% of infants are fully immunized; (2) where measles outbreaks continue to be common and case fatality rates are high; (3) where less than one-half of the population has access to clean water & sanitation and diarrhea is a major cause of mortality among under-5s; and (4) where malaria is endemic and a major killer of children for lack of preventive measures (ITNs) and adequate treatment. This describes the public health situation in today's Nigeria. Thus, a high-coverage routine vitamin A supplementation program can provide a significant measure of protection for the most vulnerable children in Nigeria, especially in the near term, while basic public health services are reestablished.

At present, vitamin A capsules are administered to children with high coverage (>90%) only once annually through NIDs (most recently, during the October 2002 NID). NIDs are projected to continue through 2005 (ICC Subcommittee: FMOH, NPI, WHO, UNICEF, USAID, BASICS, and Polio Plus). Additional sub-NIDs are conducted through the year, especially in the northern region (where Vitamin A deficiency is believed to be most prevalent), and could provide a vehicle for delivery of the second six-monthly dose of Vitamin A in the near term. In addition, Helen Keller International has successfully piloted delivery of Vitamin A capsules in conjunction with the Community-Directed Treatment with Ivermectin (CDTI) Program for onchocerchiasis eradication (see HKI description below), which covers 24 states in northern Nigeria. This program may also deliver an annual dose of albendazole for lymphatic filariasis (elephantiasis) eradication. However, the voluntary community-directed distributors (CDDs) for ivermectin have begun to demand payment for services in line with payment of NIDs vaccinators, raising a question about the potential to sustain and expand this model for the delivery of other community health interventions, including vitamin A capsules.

Nigeria appears to be moving toward a health facility-centered primary health care delivery system with active community outreach and health promotion, whether it is the Ward Health System proposed by the NPHCDA, the CAPA model that has had substantial support and "ownership" in Lagos, Kano and Abia States, UNICEF's Essential Package of Care (to be expanded to 108 LGAs by 2004), or other

variants. At this point, however, facility-based service delivery is very weak (lack of funds, trained staff and supervision, drugs and vaccines, etc.) and there is a basic distrust in the community that local health facilities can provide quality service and treatment. While various policies call for routine Vitamin A supplementation to be integrated within facility services, including IMCI, there is no evidence that this is happening at a significant level, even within BASICS' target LGAs (BASICS' support of Vitamin A supplementation to date appear to be largely constrained to NIDs-based delivery). Further, there are no country examples that can be cited where high routine Vitamin A supplementation coverage (>70%) has been achieved through "routine" contacts with children in facilities (e.g. EPI and other well-child and sick-child visits). This may be the desired goal in the future, but practically for the forseeable future, Nigeria is likely to only achieve high routine Vitamin A supplementation coverage through an active community mobilization approach. This has been done with great success in many countries, including Ghana and Zambia, by mobilizing communities semi-annually to seek Vitamin A supplementation for children at local facilities at a cost of ~25 cents/child/year. By scheduling them at the same times each year, they are routine. Child Health Weeks can provide flexibility to families as to when they can bring their children to the facility, spreads out attendance for the facility health workers, and it allows facilities to provide multiple services (VACs for children and postpartum mothers, vaccinations, ITNs & dip solutions, water treatment, iron/folate supplementation, anthelmintics, etc.). Importantly, by building such service delivery around Vitamin A supplementation, it can establish a level of trust and confidence in the community that their local health facility can provide a highly effective service to protect the health of their families. It should be stressed that routine Vitamin A supplementation should not be restricted to Child Health Weeks, and there is also an urgent need for facilities to be strengthened in the use of VA supplements in the case management of measles, severe/persistent diarrhea, PEM and xerophthalmia.

A task force has been formed to consider options for routine Vitamin A supplementation, with UNICEF taking a central role. Other "players" are likely to be NPC/NCFN, FMOH/Nutrition, and NPHCDA. It should be noted that routine Vitamin A supplementation is not even mentioned in NPHCDA's *Plan of Action for the Delivery of the Ward Minimum Health Care Package in Nigeria*, presumably because it is expected that this will be covered under full IMCI implementation under this package. USAID/Nigeria and BASICS should actively engage with the task force and bring USAID's extensive global experience in establishing high-coverage, national routine VA supplementation programs to bear on the development of Nigeria's non-NIDs strategy.

Food Fortification

Nigeria is moving quickly forward in establishing a national food fortification program. A national policy has been established for mandatory vitamin A fortification of wheat flour, sugar and cooking oils. Already, 85-90% of wheat flour millers have begun fortification, 40% of oil processors are fortifying their products, and the two major sugar companies, Dangote and ED & F MAN (~80% of total market share), are committed to launching fortification in January 2003. A logo for vitamin A fortified foods has been designed and launched. While there has been hesitancy to address more than vitamin A, there is obviously a need to move forward with iron, folate and other B-vitamin fortification of flours, especially given Nigeria's expressed interest in life-cycle approaches to health, human capacity and productivity, and the link between nutrition and chronic illness.

UNICEF also has the lead with government agencies (NPC/NCFN, FMOH, SON, NAFDAC) on fortification. The International Institute for Tropical Agriculture/Ibadan (IITA -- see description below) is also a key institution, especially as the lead in conducting and analyzing the National Food Consumption and Nutrition Survey. While there has been interest in putting a GAIN proposal together

to meet the December 15 deadline for the first round of GAIN Implementation & Strengthening Grants, Nigeria is likely to have a much more competitive proposal if they work toward a June 2003 submission, so that they can draw on the rich trove of data from the National Food Consumption and Nutrition Survey, develop a specific plan for fortification within the National Plan of Action for Nutrition, document the establishment and functioning of the National Fortification Alliance, and perhaps have some key individuals attend the IVACG/INACG Meeting in Marrakech, Morocco in February where the initial GAIN grants will be announced and discussion around GAIN may inform the development of Nigeria's GAIN proposal.

There is a danger that fortification is being oversold, an experience common to many countries establishing national fortification programs. It is being suggested that fortification may eliminate the need to supplement children with vitamin A, and has already led to a policy recommendation that children only be supplemented from 6-24 months of age. There are plans to establish a national nutritional surveillance system (possibly linked to the integrated infectious and non-communicable disease surveillance system) that can monitor nutritional status and program impact across the country as the National Plan of Action for Nutrition is implemented. This should be supported and used to evaluate whether routine supplementation, particularly Vitamin A for children 6-59 mo of age and iron/folate for pregnant/lactating women, can be reduced or more narrowly targeted.

UNICEF is apparently developing a proposal to the Micronutrient Initiative for a "bridging grant" that would support preliminary fortification activities and provide some assistance in the development of a GAIN proposal. UNICEF expressed great appreciation for the technical assistance of Dr. Omar Dary from MOST and indicated their interest in USAID supporting Dr. Dary's technical assistance to the Nigeria program in the future.

Infant Feeding

Nutrition has been one of three technical focus areas (along with immunization and malaria) for BASICS' community-level work in Lagos, Kano and Abia States. Implementation of nutrition activities, primarily promotion of better breast feeding and complementary feeding practices, through Catchment Area Planning and Action (CAPA) programs in the target LGAs is at an early stage (even though the BASICS agreement will expire in 2004), and there is little evidence to date that these activities have had measurable impact, e.g. early initiation of BF, exclusive BF rates, introduction of CF at ~6 mo, quality and frequency of CF in well and sick infants, duration of BF.

USAID's experience in multiple countries, including Zambia, Madagascar and Ghana, has shown that while infant feeding behaviors are not easily changed, community-level programs can be taken to scale and significantly improve infant feeding practices. While more than 90% of Nigerian mothers breast feed and predominant breast feeding is the norm, <20% of mother exclusively breastfeed for even 3-4 months. In addition, complementary foods are introduced late (> 6 mo), are of poor quality, and babies are fed infrequently. It is estimated that as much as 20% of infant mortality in Nigeria (105/1000) is attributable to poor infant feeding practices, so such a program could have a significant impact on IMR.

However, such a program requires establishing and supporting a trained network of community counsellors working one-on-one with mothers and through breast feeding support groups, community-based growth monitoring & promotion programs, and other channels to effect behavior change and shift community infant feeding norms. It is unlikely that such a program can be supported by USAID/Nigeria unless CS funding is substantially increased (or that program links are made and

budget shared across CS, FP (LAM), and HIV/AIDS (PMTCT)). It is also unlikely that BASICS present approach, which is very message/knowledge-based and lacks a focused community-level component is likely to achieve significant impact on infant feeding practices.

Infant feeding is a key element of child survival in Nigeria, and it will become more so in the context of the HIV/AIDS epidemic and PMTCT. While USAID/N should continue to use its offices at the policy level and in its engagement in the development of national strategies for nutrition and primary health care to promote appropriate infant feeding practices (as well as the other Essential Nutrition Actions), the lack of funds to support community-level action should temper expectations of measurable impact in a bilateral program.

C. IMMUNIZATION

> *We don't have vaccines.*
> CAPA Leaders (Abia, Kano, Lagos)
>
> *There is no shortage of BCG in the country.*
> NPI Director
>
> *We are lacking DPT vaccines*
> Health Worker, Maidan Health Center, Lagos
>
> *The awareness us there [for immunization]. We lack the vaccines.*
> Honorable Commissioner for Health Lagos State

Nigeria has a long history of implementing the Expanded Program of Immunization (EPI) starting with pilot efforts in 1975, and revising the strategy in 1984 with major inputs from UNICEF. The Government started increasing the inputs: funding, logistics, transport, power generators, IEC materials and training packages, organizing a series of national and state immunization days(NIDs and SIDs). National coverage was less than 15% in 1983.

The special efforts eventually yielded annual coverage rates of 95% for BCG and 65% for DPT3 in 1990, but slipped to below 20% after the election debacle of 1993. In 1996, NPI was subsumed by the Family Support Programme under the purview of the Office of First Lady, and her son was a major vaccine contractor. This period witnessed the importation of vaccines of doubtful quality through unusual sources.

In 1997, Nigeria became part of the international polio eradication effort and renamed its EPI program the National Program of Immunization (NPI), which is now a parastatal agency related to the Federal Ministry of Health. This new agency focused most of its attention on the frequent National Immunization Days (NIDs), but after five years, routine immunization coverage is still low, in the 20-40% range, and wild poliovirus is still circulating. A 2001 national survey on the status of PHC in 202 LGAs found that 9.4% did not offer a routine immunization program. During that year, over 28,000 cases of measles were officially reported.

Various agencies and partners (including NGOs and research institutions) that are supporting immunization services in the country. In addition to the NPI, activities are supposed to be coordinated and organized through an Inter-Agency Coordinating Committee(ICC). The ICC is also key to Nigeria's successful GAVI application. In recent months, the ICC has become more pro-active, in particular encouraging more emphasis on routine immunization.

NPI sought the support of the Global Alliance for Vaccine Initiative (GAVI) to provide Global Funds for Children's Vaccines (GFCV) for 5 years (2001-2005). Nevertheless, the NPI has continued a procedure of contract procurement of vaccines started under the military regime, and does not avail itself of the cheapest source of quality antigens, namely, UNICEF. Responsibility for vaccine distribution remains in Federal hands, unlike the essential drug supply which is procured directly by state and local government health authorities. Although strong and efficient central procurement could insure quality and availability of vaccines, in practice there are many questions about NPI effectiveness and there is growing tension between states and the Federal bureaucracy on this issue. States and LGAs are increasingly frustrated by frequent vaccine stock-outs, despite central level assurances that vaccines are in stock. Transportation problems plague delivery and/or pick-up of supplies between national, zonal, state and LGA stores.

NPI acts as a vertical program, with all resources controlled at the center. Immunization is not yet effectively integrated into the PHC system. This is a consequence of wider systemic weakness in the health sector. The central control of immunization activities is an anathema to the 1988 National Health Policy that states that PHC is the major health care delivery strategy for the nation, and that its delivery is vested constitutionally in the local government authority. Immunization, as one of the eight essential elements of PHC, clearly should be a major local priority and responsibility.

In the last 2-3 years, immunization activities have focused overwhelmingly on NIDs for polio, based on a global agenda and donor funding. There is very little activity in routine immunization at fixed PHC facilities. The surveillance system for life threatening vaccine preventable diseases (VPDs) and other childhood illnesses also has suffered.

> *Sometimes they [the vaccinators] pour vaccine under a tree, take the money and run away.*
> Post-NID Vaccination Briefing

During the field visits, the assessment team interviewed villagers, CAPA Committees, Health Staff, three State Commissioners of Health, UNICEF and WHO. All raised an alarming note about the non-availability of vaccines in the country and many expressed concern about the handling of resources by NPI.

During the re-launching of EPI in the late 1980s, several donors including USAID contributed to the training-of-trainers and in-service training to enhance the ability of LGA EPI staff to forecast, plan, manage, mobilize, educate and evaluate. USAID made a major investment in national and state M&E systems to track and evaluate immunization progress.

UNICEF built cold chain capacity in a comprehensive and reasoned manner from capital to zonal to peripheral levels in each state. This capacity was nearly completely undone in the 1990s. It is a common phenomenon that health staff and supervisors lack skills to perform the immunization-related tasks. The vehicles, power generators and cold chain equipment provided by donors were frequently poorly maintained. When they broke down, often they were not repaired or replaced.

The present centralized system relies on a "push" mentality when stocks and transportation are available. Local skills at forecasting and advocacy are either non-existent or irrelevant in such a non-responsive system. (It is difficult to assess which.) One of the reasons for low coverage during NIDs is selection of boys belonging to a political outfit as vaccinators: they are known to have given false

figures for coverage of children. NPI and state ministries of health have taken steps to alleviate this problem.

Between 1994 and 2001 the BASICS I program addressed the issue of immunization through a coalition of community based organizations and private health care providers known as Community Partners for Health (CPH). CPHs advocated with LGA health departments to ensure that vaccine supplies were provided to their member private clinics, thus ensuring a routine immunization program at the local level in 16 communities in three states. Later, as NIDs rose in prominence, CPH members volunteered as vaccinators and guides and enabled the LGA health staff to access a sceptical and sometimes resistant community. Although these small-scale efforts did not do much for LGA coverage figures, they did build community capacity in advocacy and program planning.

The USAID Nigeria program has provided money and a mandate that requires BASICS to actively participate in the multi-donor / government Polio eradication effort. BASICS' role is in training at the national, state and local government level. The polio program consumes a significant share of BASICS' child survival resources and is mainly used for training and communication.

The Sensitive Surveillance System helps in deciding about mop up rounds whenever wild polio virus is detected. The key indicator of the quality of the surveillance system is a non-polio acute flaccid paralysis rate of > 1 per 100,000 population, which means that all cases of AFP are being detected. This has not been achieved in Nigeria, as the non-polio AFP rate in 1999 was 0.4.

UNICEF is taking action to provide appropriate cold chain equipments within a national cold chain replacement plan and to ensure maintenance of cold chain equipment. It is expected that appropriate transport facilities (motor cycles / bicycles) will be provided to assure delivery of vaccines and services. WHO has established Surveillance Units in all states and FCT for Integrated Disease Surveillance.

The NPHCDA works very closely with the LGAs through a system of Zonal PHC Coordinators and Zonal Technical Officers in charge of supervision of the PHC System in LGAs. NPHCDA facilitates the formation and functioning of the three tiers of committees : the LGA Development Committee, Ward Development Committee and Village Development Committee. NPHCDA is already monitoring essential drugs through these committees which are also in a good position to manage the vaccines at the level of LGA / Ward / Health Posts.

Current coverage figures reinforce the fact that parents are either not seeking immunization for their children or are not successful in their attempts. A qualitative study in 2001 commissioned by JHU/CCP found that respondents did not spontaneously link immunization with things people do to prevent childhood diseases. On direct questioning, most were aware of immunization programs. Factors that inhibit the program included the poor reputation of immunizations, fear of contracting diseases from immunization, fear of providers' attitudes, renaissance of certain religious beliefs and practices, lack of confidence in modern medicine, links with family planning, and personal and system logistical factors.

The communities visited expressed a lach of confidence in immunization services because sessions for BCG/DPT/ Measles / TT are conducted on an ad hoc basis. There is no fixed schedule of immunization at fixed sites on fixed days, and this is a major barrier to behavior change. The Government of Nigeria

is planning to pass a law making an immunization certificate a mandatory requirement to gain school admission for children.

D. OTHER CS ISSUES

It is logical for USAID to identify a limited number of program areas to focus its child survival investment. The three areas chosen by USAID (malaria, nutrition and immunization) account for a significant proportion of under five morbidity and mortality and bring earmarked USAID funds. Nigeria is committed to addressing these issues, and other donor funding and international movements (e.g. GAVI, GAIN, RBM, etc.) address them, so leveraging possibilities exist.

However, other major causes of child morbidity and mortality was considered in this strategic assessment. Small amounts of resources will almost certainly mobilized as part of implementation in the context of the integrated approach to which the mission is committed. Also, because these conditions are frequent occurrences among the children of Nigeria, demand-responsive programming needs to respond to them.

The major conditions that should be considered programmatically are diarrhea and acute respiratory infections (especially pneumonia). According to UNICEF estimates (based on incomplete projections from health service statistics), diarrhea and pneumonia are the second and third major causes of under five mortality (after malaria). Together, account for over one-third of under five child deaths in Nigeria. Additional child survival areas worthy of consideration in this strategic assessment are neonatal mortality and birth spacing.

1. Diarrheal Diseases

While not a major focus of donor or national child survival program attention at this time, diarrheal diseases of children were the focus of substantial national and donor investment and effort during the 1980s and 1990s (including during the past military dictatorship). One major element of this effort was widespread promotion of oral rehydration therapy (ORT). As a result, the 1999 DHS shows that - while many other child survival indicators suffered serious declines – use of ORT (either as use of ORS packets, recommended home solutions, or increased fluids during illness) increased substantially between 1990-1999. In 1999, ORT was used in over 73 per cent of episodes of diarrheal illness. A major feature of Nigeria's diarrheal disease policy and program efforts was the national decision to promote use of home-based solution (sugar-salt solution, or "SSS"), rather than emphasizing dependence on ORS packets, which might not always be accessible. During recent years, the massive promotion efforts that supported use of ORT have been substantially curtailed. In part, this is the result of shifts in national and donor focus to other health issues, including polio, malaria, and HIV/AIDS. BASICS staff working in population-level programming report that knowledge of ORT and SSS may be diminishing, especially among younger mothers, as a result of these decreased promotion efforts.

In the 1990s, the government made a policy decision to take off the market anti-diarrheal drugs that commonly were used instead of ORT. While that policy is still apparently on the books, with decreased attention on childhood diarrhea such drugs have re-entered the market. ORS packets are still imported by UNICEF, but ORS is also reported to be widely available in local markets through private sector production, distribution, and sale.

With international support, Nigeria also established diarrheal illness treatment as an element of training for health workers at all levels and in all regions. ORT is an element of the "Standing Orders" that

provide the standard of care for Community Health Extension Workers ("CHEW"s), who make up the majority of primary health care personnel in many states and localities. ORT is an element of IMCI, but IMCI has not reached any significant scale as a training approach.

Substantially less effort has been made in support of diarrhea prevention. This fact, and the limited access to safe water and sanitation by the poorer segments of Nigeria's population, have resulted in much less improvement in the prevalence of diarrhea during 1990-1999 than in the use of ORT (and the difference in prevalence may be explained by seasonal factors). Prevalence in 1990 and 1999 was found to be substantially higher in the northern zones than in the south.

The national commitment to diarrheal disease treatment resulted in the establishment of training capacity (including "diarrhea treatment units" as training sites) in all states. Training in ORT has included health workers (doctors, nurses, and CHEWs), but also teachers, midwives, and others. The assessment team was unable to verify the condition and scale of training presently ongoing. However, given the limited resources available for states, it is likely that present training investments are fewer and smaller scale than needed. UNICEF is providing limited support to overall capacity building, including diarrheal disease management, through its "Mother and Child Friendly Health Services" initiative, which has limited geographic coverage. IMCI training, which includes diarrheal disease management, is being implemented in only six of 774 LGAs.

Public sector communication support for prevention and treatment of diarrheal diseases is limited in current national, state, and local resource allocations. Presently there are not significant private sector or social marketing communication efforts focused on ORS and ORT. USAID, especially through the BASICS II Project, has developed family and community-oriented materials on care of children with diarrheal illness, in response to the demand encountered through community-based programming approaches. However, the population coverage with these materials and approaches is limited. It does not appear that other USAID implementing partners or other organizations working at community level have systematically taken up use of these materials or the promotion of diarrhea prevention and ORT treatment.

A major share of demand for diarrhea treatment is channeled to the semi-formal private sector, largely in the form of patent medicine vendors (PMVs). These PMVs appear to be especially prominent in the North, where the relative number of better trained private sector providers is smaller. In general, these PMVs have not been included in national efforts aimed at diarrheal diseases; however, a limited BASICS PMV training and follow-up effort in Kano resulted in substantially increased use of ORT and the establishment of "ORT corners" in many PMV shops.

UNICEF and WHO are both promoting the "household and community component" of IMCI; this component is consistent with the community-based approaches that USAID and its implementing partners are supporting. Any investment in this programming approach is likely to include at least ORT, and also possibly prevention of diarrhea through improved hygiene, since these are among the outcomes ("key family practices") that are the focus of HH/C-IMCI.

2. Acute Respiratory Infections

Unlike diarrheal diseases, childhood respiratory infections have not had a significant policy, program, or communication push, nor significant investment, in Nigeria. The WHO ARI program was introduced in the early 1990s, but did not receive substantial donor or government funding. By the late 1990s, the introduction of IMCI was proposed by WHO as a way of strengthening health system

response to major child illnesses including. However, IMCI has not succeeded as an overall strategy for child health, and IMCI is treated apparently separate from ARI program efforts at the national level.

During the introduction of the national ARI program, there was apparently a conflict between recommended treatment for ARI and pneumonia and the national "Standing Orders" that are the guidelines and legal standards of care for CHEWs. It is not clear that the standard of care for treatment of ARI, and especially pneumonia, has been harmonized with IMCI guidelines. This may be addressed by a review of the "Standing Orders" being carried out by the NPHCDA.

An important policy issue is access to appropriate treatment of pneumonia, especially at the community level. The 1999 DHS found that less than half of children with symptoms of pneumonia (cough and rapid breathing) were taken to a health care provider. While determinants of this low level of care-seeking are not known in Nigeria. In other countries, a major factor is access to care. WHO, UNICEF, USAID, DFID, and other partners recently reviewed all controlled field trials and major program experiences with community-level treatment of pneumonia (including USAID-supported national programs in Nepal and Honduras). This review confirmed that community health workers, adequately trained and supervised and provided with appropriate antibiotics, could safely and effectively detect and treat pneumonia, yielding significant reductions in infant and child mortality. In response, WHO has issued revised policy guidance recommending that countries consider treatment of pneumonia by trained community health care providers Because of the overlap of pneumonia and malaria symptoms, community approaches to treatment will need to consider both diseases. To date, there has been no policy-level discussion of this issue in Nigeria.

Unlike diarrheal illnesses, pneumonia cannot be managed with home care alone. It requires adequate attention and treatment by a health care provider and availability of appropriate antibiotics. Thus, ARI and pneumonia care are more susceptible to the weaknesses of the Nigerian health system than is care for diarrhea.

As opposed to diarrheal illness, there has been no major investment in training or training capacity for ARI. As noted, IMCI training has not been widely supported and is not presently a major contributor to child health related capacity development. The capacity to detect and treat ARI and pneumonia is part of UNICEF's "Mother and Child Friendly Health Services" initiative, although coverage is limited. It is not clear if present training of CHEWs, the major primary health care workers, supports appropriate treatment of ARI and pneumonia. No large scale work has been done with private sector providers to promote effective ARI treatment.

There also has been no significant investment in promotion of household level treatment of uncomplicated ARI, nor on recognition, appropriate care-seeking, and knowledge of appropriate care of pneumonia. These are included among the "key family practices" of HH/C-IMCI, and would potentially benefit from investment in this approach. BASICS II has prepared household-level information on management of children with ARI. Unfortunately, this information has not been widely disseminated.

3. Neonatal Mortality

Despite the fact that, according to 1999 DHS estimates, neonatal mortality makes up almost exactly half of infant mortality in Nigeria (37 of 75 deaths per 1,000 live births), there is no coherent program aimed at newborns. The team does not foresee a substantial USAID effort specifically aimed at

newborn mortality. However, several of the elements included in USAID's PHN program approach have the potential of achieving substantial improvements in newborn health. Any reproductive health efforts aimed at improving management of labor and delivery, especially in management of obstructed labor, would be expected to have a substantial impact in improving newborn survival. Efforts to increase intermittent presumptive treatment of malaria and promotion of bednet use for pregnant women are expected to result in reduced numbers of low birth weight babies; this will also contribute to improved newborn survival. Success in promotion of immediate and exclusive breastfeeding is probably important parts of USAID's child nutrition and PMTCT efforts. It will pay off in significant reduction of risk of newborn infection and associated morbidity and mortality. This may be augmented by routine vitamin A supplementation of lactating mothers. Finally, immunization efforts aimed at increasing coverage with tetanus toxoid immunization among reproductive age and/or pregnant women will result in reduction of neonatal tetanus, still a significant cause of newborn mortality in Nigeria.

4. Birth Spacing

Nigeria faces enormous demographic challenges. Continued high birth rates lead to a rapid expansion of the young dependent population. Based on U.S. Bureau of the Census projections, 71 million of the total 123 million Nigerians are in the "dependent" age groups (19 and below, 65 and above). This means that every "productive" age Nigerian needs to support 1.35 dependent persons in the economy. Despite growth of the productive age population, by 2020 the dependent to productive person ratio will still be about 1.20. This neglects the negative effects of AIDS, which attacks mostly persons in their productive years. Thus, Nigeria's demographics create a tremendous negative drag on its efforts to escape from national poverty and ill health. Reduced fertility, facilitated by voluntary family planning, is one key input required to improve this demographic situation.

As USAID examines the potential family planning elements of its program strategy, it is important to take into account the potential positive impact on child survival (and maternal mortality) of a focus on birth spacing. Multi-variate secondary analysis of Nigeria's 1999 DHS data reveals that longer birth interval (both 2-3 years and $\geq$ 4 years) is one of the most highly significant variables associated with lower newborn, infant, and under five mortality. Birth spacing also contributes to lower maternal risk, especially in populations like Nigeria's where women's health and nutrition status is often compromised. Birth spacing is also consistent with Koranic views of reproductive health and child care. All fertility reduction contributes to reduced lifetime risk of maternal death.

IV. ASSESSMENT RESULTS : CROSS-CUTTING AREAS

A. BCC

Inventory of BCC and Media in CS and GDO

IP/Partner	Child Survival Interventions			Other
	Malaria	Nutrition	Immunization	
JHU-CCP		EBF PSAs for BASICS	Work with NIDs ICC, chair communications committee	HIV Hotline in Lagos; Assist PPFN produce posters, PSAs, etc; VISION: conduct materials review, HSB Baseline and

				new materials development
UNICEF	IMPAC promotion of nets as reward for ANC, Immunization completion as stimulus for community demand	Baby Friendly Hospitals = 1500 = promoting EBF	Social mobilization consultants for NIDs in 12 high-risk states	Launching of WCFHS by First Lady
NetMark	Private sector ad agencies to stimulate net demand			
BASICS II	Training of community health promoters (CHPs); Home Health Booklets in English and local languages; Counseling Cards in local languages and English; Job aids on essential nutrition package with messages (note most CAPAs started with immunization or nutrition)			
DfID	Private Sector Promotion			
Policy-Futures				HIV reporting and advocacy through Journalists Against Aids (print media)
PSI				Promotion of Gold Circle Condoms and Safe Sex Behaviors
LEAP				Radio for teacher training in basic education skills
FHS/IMPACT				HIV comics, drama, etc.
CEDPA				CPHs outreach, drama on FP promotion
VOA				

B. COMMUNITY APPROACHES: MODELS OF COMMUNITY APPROACHES IN USAID PARTNER PROGRAMS

Community members are the ultimate consumers of child health services and interventions. The community is where demand is created and behavior changes. In order for services and intended

health behaviors to be culturally acceptable and realistic in terms of local norms and resources, the community needs to be involved in the process of planning, implementing and evaluating intervention efforts. Concepts of community involvement or participation, therefore, form the bedrock of many community health programs, especially those emanating from the philosophy of Primary Health Care as embodied in the Alma Ata Declaration. Community approaches are important as means to achieve ownership, sustainability and local buy-in where governments are scarce. These practical and philosophical justifications for community approaches need to be backed by observable results.

It is one thing for providers to be talking; it is another for the community to be talking.
Lagos CAPA Committee Chair

The community is the one you want to serve, so you have to involve them. Without the community, you can do nothing.
Community Chief and Abia CAPA Leader

Nigeria is emerging from an era during which participation by civil society in governance was actively discouraged. Decision - making processes are still highly centralized, and allocation of internally generated revenues reflect this, as local governments receive only 10% of the national budget. Local governments, especially rural ones, are dependent on the Federal subvention for their revenue, most of which goes to pay staff salaries. State governments have the power to dissolve elected local councils. Local government health workers are employed by a state civil service commission. They can be transferred at will and, therefore, are not accountable to the local government council that pays their salaries. The electorate pays less that $2 annually in local government head taxes. This produces a situation where there is little incentive to hold government accountable. In this environment, efforts to build community involvement into health programs face up-hill challenges. Community members need to be convinced that their advocacy efforts will make a difference. In addition, health workers, who receive little training in community organization, after lack the skills to approach and involve the community.

The National Primary Health Care Development Agency (NPHCDA) has been a voice for community involvement for 10 years. The agency is charged with providing technical assistance at the LGA to implement the National Health Policy of 1988, which designates PHC as the basis of the nation's health strategy. PHC is constitutionally vested in the local government. Key to the national PHC strategy is community partnership with health staff and other intersectoral development agencies through village, district and local government level "Development Committees." Although these have not functioned well in the past, the NPHCDA is trying to revive the concept on a political ward basis by ensuring that communities are responsible for organizing and overseeing the work of their local health clinics. The ward as a unit of intervention has the benefit of being linked to census and enumeration track information for planning and evaluation.

NPHCDA Clinic Project as of June 02

ZONE	Contracted	Complete	Handover	% Handed
NC	21	20	18	90.0
SE	17	16	3	18.8
SW	29	29	7	24.1
SS	11	11	7	63.6
NE	17	17	12	70.6
NW	23	23	17	73.9

TOTAL	118	116	64	55.2

Plans have been made to carry out a revised approach in 200 local governments across the country. A Ward in each LGA that had no health facility was chosen for facility construction. As of June 2002, 116 facilities had been built and 64 have been handed over to the management of the Ward Development Committees (WDCs). The choice of ward is intended to link health clearly into the political process, and the wards local government councilor is a member of the Ward Development Committee (WDC). The concept of Village Development Committees (VDCs) was retained, and each VDC nominates a representative to the WDC. WDC management responsibilities include a Bamako Initiative type revolving drug fund started with N500,000 seed grants, receiving and monitoring equipment, and planning other supportive and community development activities.

The NPHCDA is not at present planning replication in other wards, but hope that they have demonstrated a streamlined and cost-effective model that the LGAs themselves could implement in their remaining wards. There are rumors that the Federal Government might fund construction of additional wards in the coming year. The close linkages between political WARDs and the NPHCDA may be one factor in dampening donor enthusiasm for the new PHC scheme.

UNICEF has developed a community-based approach to fostering healthy household and community behaviors. They identified 100 focal LGAs and chose two focal communities in each. The NPHCDA has only recently learned of this plan and has not been provided with a list of the LGAs. UNICEF plans to inaugurate a "minimal basic package" for Women and Children Friendly Health Services (WCFHS) in the local facilities and to engage in community mobilization to foster utilization of these services and other healthy behaviors.

At present, five USAID-supported programs are using a community-based approach. These are outlined in the attached table and include the following:

- Catchment Area Planning and Action (CAPA) Committees of BASICS II in 20 LGAs in Abia, Kano and Lagos States
- Community Partners for Health (CPH) –Started by BASICS I as CBO and private provider health and development coalitions in 16 communities, 10 LGAs in Abia, Kano an Lagos States – currently collaborating with CEDPA to include RH/FP services. CPHs have actually demonstrated a process for linking CS, RH, HIV, Adult Education, Occupational Training, micro-credit and D&G at the community level.
- ENABLE – a CORE funded project run by CEDPA that experimented with linking D&G and reproductive health activities in local chapters of three large membership NGOs in Plateau, Ondo and Enugu States.
- LEAP promoting basic education and involving PTAs in Nassarawa, Kano and Lagos to creating local school environments conducive to promoting literacy and numeracy
- PSRHH - Promoting Sexual and Reproductive Health and HIV/AIDS Reduction – a joint USAID/DfID project that relies on SFH/PSI for commodities but involves ActionAid in community organizing, initially in 13 high risk communities near the 13 SFH/PSI field offices.

The following chart summarizes community programs

Program		Partner	Sector/Technical Area
WHDC	Ward Health Development Committee	NPHCDA	PHC – WHDCs in 200 Wards with no health

			facility
CAPA	Catchment Area Planning and Action	BASICS II	CS in 20 LGAs, 3 States
CPH	Community Partners for Health	BASICS I CEDPA	CS, RH primarily but also used for HIV, micro-credit, Female Adult Education, Occupational Skills Training, D+G
PTA	Parent Teacher Associations	LEAP	ED – producing enabling school environment for literacy and numeracy
PSRHH	Promoting Sexual and Reproductive Health and HIV/AIDS Reduction	PSI, ActionAid through USAID and DfID	RH, HIV – social marketing through PSI, community mobilization by ActionAid
ENABLE	(through local NGOs like COCIN, COWAN)	CEDPA	RH, D+G, HIV/AIDS
WCFHS	Women and Children Friendly Health Services	UNICEF	CS, Safe Motherhood in 200 communities in 100 LGAs

USAID supported community level programming efforts in Nigeria have demonstrated the potential success of such approaches to:

- **Increase resources for health** – Programs have obtained financial and human resources from individuals and non-governmental organizations.

- **Increase demand for health services** – Programs have mobilized communities to seek and advocate for services.

- **Use community channels to disseminate of information** – Through local organizations such as women's groups, churches and mosques, trained community health agents, and special events communities augment their ability to disseminate information. Except for the polio NIDs, to date local information dissemination efforts have rarely been harmonized with mass media campaign.

- **Link government services with communities** – The BASICS II CAPA approach specifically partners local government providers and managers with communities by focusing community organization around government facilities. This is a principle successfully implemented at scale as a fundamental element of the Bamako Initiative, which Nigeria has adopted as part of its national primary health policy.

- **Support distribution of key commodities** – CEDPA has successfully developed contraceptive CBD approaches in Nigeria based on community organization developed under BASICS I.

Community approaches might help provide supervision and quality control of health services. Given the lack of capacity for supervision ad quality control by government health services, it is possible that the demonstrated ability of USAID-supported community programs to engage with health services could be systematized to create effective monitoring and supervision of those services.

CAPA is the major model of community-based intervention in Child Survival. CAPA builds on the BASICS I CPH model with CBO and private health facility involvement, and focuses it on the local government primary health care system in 20 LGAs in Kano, Lagos and Abia States. CAPA creates state-level multi-sectoral teams of trainers in both the technical areas of immunization, nutrition and malaria and in the process of establishing community involvement in micro-planning at the LGA primary health center (PHC) level. State trainers train LGA teams that in turn bring together CBOs, private providers and PHC staff who form CAPA Committees. There number of CAPA Committees in each LGA, ranges from 5 to15.

The committees prioritize and focus on one of three technical areas as a starting point for planning and action. They are nevertheless encouraged to think more broadly about future community health needs CAPA Committees examine factors that influence quality of care at the facility and within the catchment area. They have tackled such problems as adequacy of seats in the clinic, availability of syringes to perform immunization and improvements in client-consumer interaction. The committee monitors the facility and the services it provides.

Since the Committees include as members both local CBOs and private providers, they can continue to function even if LGA political officers or health workers change or are transferred. LGA and State level Inter-CAPA Committees are being formed to advocate for health and development improvements. The Committees are expected to be self-financing, a challenge that also applied to the sustainability of the CPHs. LGAs were usually reported being short of funding.

The CAPA approach most closely resembles what the NPHCDA is trying to achieve through its WDCs. Focus on the facility by CAPA resembles the earlier approach of PHC implementation by the FMOH which relied on the concept of a health district as the area served by a health facility. Since a facility may serve more than one ward or a ward may have more than one facility, the CAPA model does not correspond geographically to the political empowerment and participation goals of the WDCs. On the other hand, the CAPA model may be more inclusive in that it tries to involve all interested CBOs in an area. In the WDC model, CBOs may or may not be included in VDCs, which are the basic representative unit on the WDCs. Ultimately, each model aims at promoting community ownership and involvement, though the WDC model states clearly that the health facility belongs to the community.

BASICS and the Tulsi Chandrai Foundation (TCF) are the only two potential partners that responded to an NPHCDA call for collaboration. TCF is about to start work in one GA in Kaduna State as a LGA partner in PHC. BASICS has not followed-up with a specific plan, but the Southeast Zonal office of NPHCDA has contacted the BASICS field office in Aba to see how TA could be provided to the 31 LGAs in the zone NPHCDA has identified. One, Aba South, is a focus of both agencies.

Several issues remain for USAID's community level program approaches to be effective investments for achieving PHN impact at meaningful scale. These include:

- **Simplification, streamlining, and consolidation** – USAID's implementing partners in PHN and other sectors (agriculture, education) have developed a multiplicity of approaches to community-focused programming. This diversity results in fragmentation of USAID's investment in community approaches as well as potential confusion of communities and partners as these approaches expand and overlap. Some of the approaches involve intensive processes covering relatively small populations, limiting the feasibility of expansion and replication. USAID and its IPs need to identify

essential elements of the various community approaches and move toward a simplified and shared approach. Partners such as UNICEF and NPHCDA can be included.

- **Achieving scale** – Streamlined, approaches will facilitate greater scale of programming. Presently, even in the most ambitious USAID community-focused approaches, The population actually reached by intervention is relatively small compared to the overall target population in USAID-assisted areas. The focus needs to shift. Developing consensus and ownership among other partners and government also is necessary to go to scale.

- **Understanding and applying concepts of base population, coverage, and monitoring** Answering key programmatic questions such as "What number of people in the target age group are we trying to reach?" or "What proportion of those people are practicing the desired practice?" is fundamental to effective programming. The team found, that most of the community groups being assisted by USAID, either do not know these basic data or do not routinely use them in planning. For example, the smallest CAPA areas include approximately 3,000 children under age five.

Failure to manage numbers can result in efforts that appear positive, but have little public health impact. For example, in one CAPA with an estimated 2,000 infants under age one, the CAPA was pleased with an increase in the number of children attending clinic for vaccination monthly (from under 10 to about 70). Unfortunately, since each infant requires five clinic sessions to be fully vaccinated, the monthly requirement would be over 800.

Although the community primary health care scheme proposed by NPHCDA has several drawbacks, one advantage is that it includes clearly defined target populations, as well as proposed indicators and measurement techniques to ascertain the status of those indicators. USAID needs to focus on "denominators" and on monitoring coverage.

Achieving a "critical mass" of intervention – Achieving behavior change often requires a complex set of interventions, repeated often, reinforced at severals levels of communication and by multiple interactions. This notion of "critical mass" or density of intervention presents an important challenge to Nigeria's community efforts.

- **Focusing on and delivering outcomes** – The community-based approaches the team observed seemed to focus more on processes than on health outcomes. While these actions facilitate outcomes, those outcomes were less clear. Achieving health impact through community efforts requires clearly defined health outcomes, and specific objectives to give a sense of accomplishment. One example of this is the "Champion Community" approach implemented in Madagascar. Under this approach, communities set indicator goals and are awarded "Champion" status when those goals are achieved.

- **Reaching the hard-to-reach** – Communities themselves are in the best position to identify least-served families and children. They are often able to identify the best tactics for reaching those families and children with interventions.

SYSTEMS AND CAPACITY

Health is placed on the concurrent list of schedules in the Nigerian Constitution, with all levels of government responsible for providing some form of health care to the people. The health system in Nigeria is developed around the three- tier form of Government, i.e., the Federal, State and the Local Governments which shoulder the responsibility of providing tertiary, secondary and primary health

care respectively. There is, however, an overlap in the practical delivery of health service such that state health facilities may be engrossed in providing primary health care services.

> *The linkage between the facility and the community is relatively easy to achieve. It is harder to achieve a mentality change in the civil service structure to support the facility.*
>
> Chief, Health & Nutrition UNICEF

Health policies are formulated jointly by the Federal and State Governments, mainly through the National Council on Health (NCH) and the State Councils on Health (SCH), but the mode and degree of implementation of policies is dependent on locally operating factors at each technical and/or geo-political level. All levels of government share the constitutional responsibility of providing CS services. Policy formulation in the health sector has only infrequently involved the private sector in the past.

Although many CS and other PHC interventions were developed and implemented based on National policies and conventions, their practical implementation has had limited success due to obstacles in planning and design, particularly the deficiency in the community empowerment component. In addition, the formulation of interventions has largely been top-down and not consultative.

The NPHCDA, the primary instrument by which the federal government channels CS support to the States and LGA's, is divided into 6 Zonal offices, one each for the 6 geo-political zones in the country as follows:

* North East Zonal Office – Bauchi
* North West Zonal Office – Kaduna
* North Central Zonal Office – Jos
* South West Zonal Office – Ibadan
* South East Zonal Office – Enugu
* South South Zonal Office - Benin

In addition, the NPHCDA stations three to four technical staff at the headquarters of each of the 36 states and Abuja, called Zonal Technical Officers, who carry out routine supervision of PHC in the LGA's. To support the NPHCDA, the Federal Ministry of Health (FMOH) maintains a Department of PHC and Disease Control, now re-named Department of Public Health, which deals largely with its counterparts in the States.

Other Federal Government organs that deal with PHC include the National Program on Immunization Agency (NPIA), the Department for Community Development and Population activities, NAPDAC, and various University teaching hospitals across the country.

The State Ministries of Health provide CS/PHC services through their Departments of PHC and Disease Control. The Hospitals Management Boards provides clinical child care through the general hospitals, but the bulk of PHC/CS services are provided by the LGA's in the primary health clinics and centers. The LGA's also maintain a Department of PHC which plans, coordinates and monitors the delivery of the CS services.

PHC service is the backbone of the country's health system and, although it's provision rests on the LGAs, the NPHCDA is officially assigned to provide all the technical and financial support it requires throughout the country. In addition, the Federal Ministry of Health has departments established to support States and LGA's in the provision of CS and broader PHC services. The States, in reality,

provide LGA's with a lot of financial and technical support in PHC and CS. The NPHCDA has the additional responsibility of seeking and coordinating donor support to States and LGA's on PHC. This task is, however, generally pursued by the Federal Ministry of Health and the National Planning Commission.

In the area of manpower development, Federal and State Governments train all levels of health personnel in the Universities, Schools of Nursing, and Health Technology. These institutions also conduct a variety of in-service training courses for health workers, in additional to their expertise in the provision of on the job, hands-on skill training.

Technical support and coordination of PHC has been provided by numerous donors. External support to PHC and CS constitutes a formidable proportion of resources that are channeled into capacity building and service provision. Bilaterals and the UN agencies dominate this arena, although a few NGOs provide some support. Donors have also established coordinating offices in the geo-political zones. The World Health Organization (WHO) has just completed the establishment of offices in all the states of Nigeria. The WHO has expressed its unreserved willingness to make the facilities in the state offices available to all other donors/partners.

The PHC in Nigeria is designed to be comprehensive, provided, integrated health care throughout the entire system, with a well-coordinated two-way referral system. In addition, the package is to integrate home/community-based care with clinic-based health care. It is along this line that all PHC personnel receive training in the various schools of health technology and universities.

Therapeutic guidelines called the **National Standing Orders** are designed to provide practitioners the necessary technical and legal support and reference in their interactions with patients. In spite of this, a number of health care packages, from the Bamako Initiative to Minimum Health Care Package, BFHI, IMCI and more recently C.OPE and WCFHS, have attempted to provide comprehensive CS/PHC services. The two most current additions to the array of health care packages are the CAPA and the Ward Health System (WHS). All these packages are well thought out but appear to have been elaborated in isolation. Most PHC workers have received training one or more of these packages.. Each PHC package is accompanied by corresponding job aids and BCC materials.

POLICY

There is an urgent need for health sector reform. We must put money where it is appropriate and most needed. In a LGA builds a clinic, don't say, 'thank you,' until the PHC services start.

Honorable Commissioner for Health, Kano State

The Nigerian Constitution and the National Health Policy provide guarantees for proper implementation of CS interventions. In addition the required infrastructural, institutional and technical capacity needed to implement CS programs is established, but the country has not been able to harness it in a smooth and sustainable manner. Some reasons include obstacles in the organizational structures of the health system as well as its size and complex social dynamics. To quote the Honorable Commissioner for Health Kano State," Nigeria is a country of 807 independent governments". This multiplicity of relatively independent governments can also be a formidable resource for the delivery of CS interventions with local decision making and innovation.

Accountability and transparency in the utilization of public funds is a chronic issue, inadequate since the military era. This, coupled with the dwindling economy, makes provision of adequate resources for social services increasingly daunting. This is one reason budgetary allocations for CS are not always released. On the other hand, there is a broad range of performance among states and LGAs on financial and governance issues. Some states and LGAs are well governed; other face victim to widespread corruption. Stakeholder analysis and tactical engagement of appropriate partners, particularly those operating at LGA and community levels, is critical to success in implementing programs. This does not seem to have been adequately employed in the past.

Agreements can be reached and signed between donors and governments for the provision of counterpart contributions to CS. This can leverage public resources appreciably. This is more possible in the current setting, as all governments claim women and child health developmental issues as their priorities, and never hesitate to use them for political purposes.

USAID interacts on the policy front in two ways: directly through USAID officers and indirectly through its IP's. Without even going to state and LGA levels, the number and complexity of stakeholders and government departments engaged in various policy arenas important to child survival is daunting. The small USAID CS technical team has done an admirable job keeping up, but faces overwhelming challenges.

BASICS has functioned as the main CS policy support IP for USAID/Nigeria. BASICS provides technical and programmatic inputs at the national level, and jointly participates with USAID on committees such as ICC, GAIN, and others. BASICS also quietly intervenes at the policy level in their emphasis states (Kano, Lagos, Abia) and in focus LGAs, and provides punctual support to other IP's. The need, however, still outstrips supply, and some key stakeholder meetings are missed because no one is available to attend. Moreover, there is a need for a technical focal point in each key area. The need for a point person in Roll Back Malaria working group was specifically noted.

USAID/Nigeria recently awarded funds to the centrally funded Policy Project to support a child survival advisor. This promises to provide some relief. In a short period, an excellent "think piece" on child survival policy issues has been drafted, and the advisor has taken the lead or backed up USAID in a couple of areas. The Policy Project also has funding and mandates to address policy issues in Reproductive Health and HIV/AIDS. Some effort is being made to address policy issues that cross sectors, although surely not enough.

The team felt strongly that the overall "policy environment" at the national level is acceptable. Nigeria has many of the right *national* policies and conventions in place, even if many require updating or more comprehensive plans. Political will is another issue, however. There are, by contrast, policy issues at the state and LGA level that impact child survival programs. For example, the politically-motivated decrees mandating free drugs and services (often translated into unavailability and in sharp contrast to Bamako Initiative guidelines) at some LGAs undoubtedly should be addressed.

In the medium and long term, the only truly significant policy issues involve budget and finance, release of funds, control of corruption, good governance and government commitment to sustainable health programs. Without relief in these areas, no sustainable progress will be made, regardless of the level of donor investments. Much more could be done to inform the overall USAID policy agenda in these areas. It is a crucial point of intersection with the democracy and governance portfolio. Some states and LGAs perform better on fiscal and D&G criteria than others, and this can be taken into

account in selecting target areas. A recent USAID assessment sited Lagos and Kano as being among the states on a positive track in terms of governance.

It was not clear how the USAID health policy agenda is formulated, what role various IP's play (and how they coordinate), and how priorities are identified. The experience of the staff at the Policy Project should be utilized to address truly urgent policy issues, even if these issues are outside an annual work plan. For example, both the Project Director and the CS Advisor said they were unaware that there is a program-threatening issue with bed net taxes and tariffs. When informed, they had good suggestions on how to proceed to resolve the issues. Mechanisms to identify emerging priorities need to be put in place. Also, the Policy Project could be a prototype for an integrated approach to policy formulation and dialogue (in RH, HIV/AIDS and CS), if appropriate USAID guidance is provided.

As it moves toward an integrated strategy, USAID needs to further focus its "policy agenda," especially given human resource constraints. Current national level activities remain important, but little by little policy activities should devolve to focus states and LGAs where they directly impact on service delivery.

Private Sector

Nigeria's private sector is broad, complex, dynamic and huge. It includes everything from tiny local PVOs to huge multinational corporations doing billions of dollars worth of business. Market forces are particularly vibrant in Nigeria, a fact reflected in the health sector.

The vast majority of poor Nigerians obtain medicines through small patent medicine vendors and local health workers, and a significant percentage of health care, especially in urban areas, is provided through private sector hospitals and clinics. Quality is a big issue from drug supply (fake drugs) to clinical quality of care and infection prevention (universal precautions to protect against transmission of HIV). Community (PMVs, midwives, etc.) and mid level (community clinics and hospitals) practitioners do not have easy access to the latest technologies and treatment protocols in public health areas. As a result, much of their information comes from drug companies motivated to sell their products or from other sources, including the often unreliable public press. An important advantage of donor-supported commercial or social marketing efforts (such as NetMark and the Society for Family Health) is their commitment to passing sound technical information through commercial channels.

In the benevolent sector, there are huge numbers of local and international NGOs, private foundations and other charitable endeavors such as the community health programs sponsored by Shell Oil. Private health providers and Non-Government Organizations (NGOs) already contribute significantly in PHC and other CS activities in Nigeria. Two notable non-governmental approaches include CHAN and CPH.

The Christian Health Association of Nigeria, headquartered in Jos, is an association of Catholic and Protestant mission health clinics, outreach programs and hospitals. CHAN has a PHC department that fosters development of PHC systems among members. CHANPHARM, with a main warehouse in Lagos and zonal offices has provided inexpensive and reliable supplies of essential drugs for nearly 30 years.

The Community Partners for Health (CPH) project of BASICS I brought together Community Based Organizations (CBOs) and private Health Care Facilities (HCFs) in 16 communities in three states. BASICS provided skills training so that these private HCFs could provide prompt and reduced cost

treatment, including routine immunization to CBO member children and serve as a rallying point for community mobilization on HIV, environmental sanitation and other health issues.

Finally, large employers usually make provision for employee healthcare, either by contracting with local hospitals or through internally managed health infrastructures. Despite being well financed and able to recruit top doctors and nurses, these organizations also often have difficulty accessing up to date information and skills in key health areas. Frequently, they are willing to pay to gain expertise, and opportunities exist to cross subsidize in-service training in given geographical areas. Evidence also suggest potential to tap the private sector to play a policy role and/or for charitable contributions. However, most businesses mistrust government, with good reason. The actual impact on numbers of children of work-based services is small, and it is not a key at risk target group.

During the previous military regime, when immunization and PHC virtually collapsed, the private sector provided a useful "safety net" for communities. Even now, when some LGAs go on strike for up to two months and services are suspended, people must rely on non-government providers. USAID has historically been the most successful donor working in the private sector, both in Nigeria and internationally.

V. INTEGRATION

A. WITH OTHER USAID PROGRAMMING

Agriculture, Nutrition & Health

The importance of agriculture and food security to nutrition and health are widely recognized. However, nutrition and health should be equally appreciated as key inputs to agricultural productivity. The lack of basic health and nutrition services extended to rural areas severely compromises the productivity of more than two-thirds of the Nigerian population, >80% of whom are directly involved in agricultural production. For example, malaria and anemia weaken farm family members and divert labor and resources within the household to care for those who are sick. Presumably, nutrition and health as both input and outcomes will be included in the upcoming USAID/Nigeria assessments of agriculture and food security. One entry point for strengthening health and nutrition among rural farming families may be through the Nigerian agricultural extension system, supported by USAID/Nigeria through the Agricultural Development Project (ADP).

Another area of strategic intersectoral investment for USAID/N is in its support to the International Institute for Tropical Agriculture/Ibadan (IITA) in selection and establishment of "biofortified" (high iron, zinc, beta-carotene) maize and legumes (beans, cowpeas). These improved varieties may be ready for release and dissemination within five years. [Note: GH & EGAT have requested Administrator funds in FY'03 for a joint initiative in biotechnology, including "biofortification". Nigeria's favorable policy on biotechnology, with established technical capacity at IITA and other institutions within country, make it a logical candidate for these funds if they are available.]

Water and Sanitation

It is unfortunate that the team did not have time to focus on water and sanitation, since it is a critical area intersecting with child survival. The literature (see bibliography) in Nigeria and elsewhere documents the relationship between clean water and sanitary practices and incidence of diarrhea, malaria (standing water), and other diseases transmitted by oral-fecal routes. Water and sanitation programs intersect with education, since school hygiene and de-worming effort can improve nutrition, school performance and break the parasite transmission cycle. Water and sanitation also is a natural

"fit" with farmer-to-farmer programs and as a likely target to be addressed in food-for-work programs under Title II. The team regrets being unable to give this area the emphasis it deserves.

Fewer than 50% of Nigerians have access to safe water and adequate sanitation, . Although USAID/N may lack funds to support a major water and sanitation initiative, USAID/N may want to link with other partners investing in this sector, including the WHO Global Water Quality Initiative, which is focused on improved transport of water, household storage, and (if necessary) point-of-use disinfection. Water disinfection might also be addressed through social marketing of chlorin packets, as has successfully been done in conjunction with Child Health Weeks in Zambia.

Education

Health education should not be an add-on; it needs to be part of the science curriculum. LEAP Director

It is well established that level of education, especially for mothers, is a key determinant of household nutritional/dietary (and health) behaviors. However, the direct programmatic links between primary education (presently the focus of USAID/Nigeria in this sector) and nutrition in Nigeria are less clear. Multi-micronutrient supplements would likely benefit a great proportion of Nigerian public schoolchildren (limited data available pending the results of the 2001 National Food & Consumption Survey), but would have much greater impact if directed to preschool-age children, especially 6-24 mo of age. At the same time, a successful national fortification program should provide micronutrients to these school children, as well as other vulnerable groups. School gardens may contribute to school feeding programs and provide a forum for educating students about diet and nutrition, but CSD Guidance proscribes the use of CSD funds for such use.

The Honorable Commissioner for Health of Lagos State asked the Child Survival Assessment Team specifically for support for a school feeding program, but this would be more appropriately directed to the USDA Global Food for Education Initiative (http://ffas.usda.gov/excredits/gffei.html). One other program link between primary school programs and nutrition/health is routine deworming, but more analysis would be needed on helminth burdens among Nigerian school children and their effects on appetite, nutrient losses, health, and academic performance.

Prevention of Mother-to-Child Transmission (PMTCT) of HIV and Child Survival

PMTCT is fundamentally *a child survival issue*. As such, PMTCT programs should be broadened to reduce the risk of MTCT while protecting the health and survival of infants and other young children in households affected by HIV/AIDS. By definition, PMTCT involves an HIV+ mother and often an infected (or deceased) husband whose ability to care for young children may be compromised by deteriorating health status. Productivity and income progressively diminish. Limited assets must be diverted for health care and households become increasingly food insecure. Thus, even in the absence of MTCT, parental HIV/AIDS erodes household resources and substantially increases the risk of malnutrition, morbidity and mortality among their children and adults.

Programmatically, voluntary counseling and testing (VCT) needs to be linked to antenatal care (ANC) and Baby Friendly Hospital services, so that HIV-infected pregnant women can be counseled on nevirapine treatment for the mother (intrapartum) and infants (postpartum) (*FMOH National Guidelines for the Implementation of Prevention of Mother-to-Child Transmission (PMTCT) of HIV Programme in Nigeria)*, as well as care and support for the mother, her infant and others in the household. VCT/ANC counseling must also assist HIV+ women to be fully informed about infant

feeding options (exclusive breast feeding or exclusive replacement feeding for the first months of life) and fully support their choice programmatically. It should be recognized that the mother's health is critical to reducing the risks to her infant: maternal CD4 counts >500 are associated with a ~10X decrease in MTCT through breast milk, while maintaining breast health (care and treatment for cracked nipples and mastitis) also reduces MTCT through breast feeding.

It is estimated that ~ two-thirds of pregnant women attend ANC clinics, although a much smaller proportion deliver in health facilities. Presently, between 1000 BFHs and 6000 BFH counselors are in place in Nigeria, although counselors are likely to have had little or no training in counseling on MTCT and infant feeding/child care. While there is a limited set of interventions that can be practically extended to HIV+ women in the present Nigeria context and the issue of stigmatism needs to be considered, it is not impractical to consider directing food (Title II?) and multi-micronutrient supplements to these women, as well as promoting use of ITNs and preventative/therapeutic treatment of malaria (linked to RBM), and treatment of other maternal infections. If the stigmatism issue is overriding, this could be done in the larger context of targeting mothers in households identified as being highly food insecure.

For those infants born to HIV+ mothers who may HIV-infected but in most cases undiagnosed, and for those who are formula-fed (or mixed-fed in spite of counseling), the greater risks of diarrhea, malaria, ARI and other infectious diseases, increase the urgency and necessity of providing basic infant/child health interventions: routine immunizations, routine vitamin A supplementation, ARI treatment, and ITNs/malaria treatment, CDD/ORT/hygiene, water & sanitation (including chlorin water treatment), and community-based growth monitoring and promotion.

In cases where HIV infection is confirmed or where HIV is suspected based on clinical diagnosis, WHO recommends cotrimoxasole prophylactic treatment for pneumocystis cariniae pneumonia (PCP). Nigeria is presently developing policies for the distribution of ARVs that will be available under GFATM support and may be directed to HIV+ mothers and infants/children. Nigeria is also revising Standing Orders, essentially standards of care, for health worker diagnosis and management of HIV-infected children.

B. INTERACTION AND COORDINATION AMONG DONORS AND ORGANIZATIONS

At one level, there appears to be good working relations among USAID and other organizations involved in RCH policy and activities. In some cases, as with the Polio Eradication Initiative, there is an active Inter-Agency Coordinating Committee - a requirement under the terms of GAVI support for routine immunization and new vaccines in Nigeria. However, at another level, the broader consensus and coordination needed to get greater impact and scale from partners' investments seems to be absent.

In terms of a model for primary health care and community involvement, several different approaches with different organizations' "brands" on them (NPHCDA, UNICEF [in addition to the Bamako Initiative], MOH, and even USAID) appear to be competing, and there does not seem to be the will or a neutral forum to reconcile differences and develop the consensus needed to achieve greater scale. The same appears to be true for impregnated bednets, for which USAID, UNICEF, and the federal government have approaches that contain fundamental differences (such as the roles of free, subsidized, and commercially marketed nets).

One approach to dealing with these resilient incompatibilities might be establishment of a "Health ICC," as suggested by the WHO Representative in Nigeria. Another might be more effective use of the National Health Council (for policy) or State Health Councils (for implementation approaches).

VI. USAID COMPARATIVE ADVANTAGES

There was a high degree of consensus among non-USAID stakeholders (including government, community representatives and other donors), USAID-funded IP's and USAID staff on the overall comparative advantages of USAID as a donor. They are, not surprisingly, similar to perceived USAID comparative advantages globally. More, however, can be done to maximize use of child survival funds (and other health funds) in USAID strategic advantage areas. Some partners, particularly community and State level partners, have exaggerated expectations of what USAID can fund. Given that resources for child survival will be modest compared to other sector investments, it is important that child survival activities focus carefully. Six areas of USAID comparative advantage are noted:

1. Technical Assistance – USAID is clearly recognized as a leader in state of the art technologies (SOTA) in all health areas. Many examples were cited, from inputs into the National Food and Nutrition Survey to assistance in developing national policies, protocols and plans that reflect the latest thinking both programmatically and technically. USAID IP's were praised for their special technical expertise and for the information and technical support they can mobilize as needed. Training (both in terms of content and adult learning methodologies) and improvement of quality of care (COPE, management for results, etc.) are valued by stakeholders. For example, UNICEF is adopting the Engender Health COPE model in their child survival program. BASICS is a major resource for all child survival partners. Commercial and social marketing—NETMARK in the case of child survival—is considered an impressive US-led technology, as is the use of modern mass media and communications techniques.

Notwithstanding severe staffing constraints, USAID and IP staff participate actively in a wide variety of policy and technical areas. The key role USAID played in launching the National Nutrition Policy is a good example. USAID/IP experts assisted in the development of Nigeria's GAVI and Global Fund proposals and in Roll Back Malaria discussions. The fact that IP's are on the ground in communities gives moral weight and adds practicality to their recommendations. IP's appear to openly share their expertise with other stakeholders. The World Bank is the one major donor that the USAID CS team does not work with on a regular basis, but others had high praise for USAID collegiality.

On the other hand, major gaps remain in the use of this strategic advantage. Notwithstanding USAID efforts to exhort IP's to "collaborate," cross fertilization in technical areas remains a weak point. One family planning partner interviewed had the barest and most general knowledge of CS issues and challenges, and CS partners often only pay lip service to reproductive health in their community programming. JHU/CCP, which is funded to do communications and mass media in all health areas, has so far not played a strategic role in integrating and cross fertilizing the health sector. The staff of the Policy Project was not aware that the key policy issue of taxes and tariffs is threatening the entire country's ITN program. The team repeatedly heard the comment, especially by IP's themselves, that "everyone works in their own individual box."

All currently operating IP's have central headquarters with strong technical staff and a global focus in their technical areas. It is, however, surprising how little technical input is being received from "headquarters" and how little SOTA technology and strategy is filtering down from the center. The synergistic blend of headquarters and local talent/knowledge that was so palpable in the early days of the USAID Population Program in Nigeria seems to have diminished. This is despite the fact that Nigeria is clearly the most important (as well as the largest) USAID-assisted country in Africa.

2. Advocacy—This is an area of historical strength of US assistance programs. The United States automatically has a "seat at the table" by virtue of being the only super power. Since "money drives policy" in Nigeria (as elsewhere), recent, dramatic, increases in USAID health sector funding also increase its influence in key policy areas. Finally, the high quality of US technical inputs and longstanding on-the-ground programs are important factors in promoting USAID influence. USAID and all IP's do "advocacy" routinely at all levels. Community activities such as CAPA have become powerful advocacy tools at the State, LGA and village levels. The Policy Project was recently funded to create tools and improve advocacy in CS. USAID and its partners globally have a lot of skill in advocacy. To date, efforts in Nigeria have only scratched the surface.

The most important long-term policy issues revolve around health sector reform, health financing and control of corruption. These are difficult and complex problems. Nevertheless, gains must be made for investments in health to be productive. Previous experience demonstrates that donor-driven programs are not durable; a fact cited by Nigerian organizations and other stakeholders. Partner donors, such as UNICEF and WHO, expressed a strong desire to work closely with USAID and the US Embassy on policy issues. Other points of entry have been international initiatives such as GAVI, the Global Fund and Roll Back Malaria. USAID/Nigeria senior staff are supportive and willing to do what it takes to advance a clearly articulated CS policy agenda.

3. Flexibility—IP's and international staff express frustration with constraints put on them by central funding mechanisms and a multiplicity of bureaucratic requirements imposed upon the program by each IP headquarters or by USAID/Nigeria. The reality is, however, that even with the current cumbersome contracting mechanisms, USAID and its partners have demonstrated a remarkable degree of responsiveness to changing needs and conditions. The rapid growth of the overall portfolio, especially in HIV/AIDS, provides irrefutable evidence of this. BASICS has provided technical support to the Nigerian Government in a broad range of CS areas, as have other IP's in their technical areas. ARCH is responding to the need to broaden their scope. Programs are finding new ways to respond to the orphan crisis. Funding for priority activities flows with a minimum of delay, compared to other donors with more cumbersome requirements to disburse funds.

The negative side of flexibility can be a tendency for programs to become fragmented or ad hoc. This is occurring in Nigerian programs, but it can be mitigated by a sound long term strategy and a strategic framework which clearly articulates results to be achieved and critical actions required to achieve these results. The next five year strategy and plan will provide this.

Although historically USAID is the most supple donor, other donors are beginning to follow the lead. In a programmatically bold move, WHO recently posted officers and administrative staff to each of the 36 Nigerian states to facilitate technical work and administration of funds. DFID built its social marketing program on USAID-funded PSI programs. Finally, foundations such as the Packard and Gates Foundations offer the possibility to leverage funds in creative and flexible ways.

4. Ability and Experience Working in the NGO and Private Sectors and Community Level Approaches—With the exception of DFID, most bilateral and multilateral programs are constrained to work mainly in the public sector. USAID has always supported a wide variety of private sector initiatives in Nigeria. During the military regime, it was the only type of support USAID provided. In the late 80's and early 90's, USAID also supported a range of activities designed to engage the for-profit, commercial private sector. Private hospitals, clinic and providers (such as private midwives)

were brought into the USAID program, as were work-based service delivery programs, commercial marketing efforts and social marketing.

The current range of private sector partners is less broad than in the past, and, unfortunately, USAID appears to have lost much of its "institutional memory" of vibrant past collaborations with private sector. In contrast, some IP's have worked with the same NGO partners for two decades or more. While this creates continuity, it does not always foster maximum creativity. Recently, USAID has begun to reclaim its strategic advantage in public-private partnerships, as HIV/AIDS, malaria and other well-funded efforts explore every available non-governmental avenue for social mobilization. Integrated programs will allow less well funded parts of the program to tag along.

CPH and CAPA programs pioneered a new model of public-private partnership by working with entire communities to mobilize them to supervise, support and advocate for local public and private health efforts. Similar community approaches evolved in other sectors. USAID remains one of the few donors to actually reach the grass roots level effectively.

5. Behavior Change and Communication—This is a historical strategic advantage of USAID programs in Nigeria and worldwide. Over time, USAID and its partners evolved systematic and evidence-based approaches to changing health behavior and community norms on health issues. All levels of communication, from village health volunteers through radio-television and mass media, have been mobilized, with demonstrated results and materials of high quality and entertainment value. Messages have been directed at promoting specific behaviors, such as immunization, use of family planning, etc.

The polio social mobilization campaign seems comprehensive, and the ITN advertising is promising. Yet overall, BCC efforts in child survival appear to be disjointed and unfocused. Their impact has yet to be measured. Notwithstanding this, BCC remains a strong area of comparative advantage, and several agencies (JHU/CCP, VOA, PSI, NETMARK, Change, BASICS, etc.) have the capacity to make a difference.

6. Results-based Approaches—USAID pioneered among international donors in putting into practice a strong, data-driven system to "manage for results". USAID/Nigeria has a rational results framework, organized under well-defined Strategic Objectives, with measurable indicators of success. Recently, USAID has stepped up its efforts to audit and verify data quality to validate results. Results-based approaches are important to orient programs and define success. On the other hand, the efforts of USAID and its IP's to manage for results is hampered by the fragmentation of the program into many parts and a need to more clearly define catchment areas, baselines and program targets. Results are often small in scale and, while at times dramatic and moving, costly in terms of programmatic inputs.

At the program level, measuring results, or even defining desired outcomes, becomes a moving target. As described by one IP informant, "This is the weakest area of our NGOs." The same is true for the CPHs and CAPA Committees. Nevertheless, based on field visits made by the team, communities do seem to understand setting objectives and goals, and they relate to the overall results-oriented USAID "culture" very positively. Communities, it seems, also hunger for results. USAID is in an excellent position to improve management and monitoring at all levels.

What is NOT in the USAID strategic advantage?

USAID has funding and competence to undertake a wide variety of activities designed to leverage other donor funding. It is not in a position to fund nationwide sector reform efforts, large scale capital building or equipment projects or subsidies to routine operations of health centers or hospitals. It can provide technical support in logistics and M&E, but has no strategic advantage in vaccine procurement (a UNICEF strength), essential drugs purchases or setting international norms and standards (the role of WHO). USAID does not normally intervene in adult degenerative diseases or at the tertiary care level, except in the case of Safe Motherhood, permanent contraception and treatment of very ill children under the IMCI algorithm. USAID has no comparative advantage sponsoring long term academic training in Nigeria or overseas, despite superb public health schools. Long-term training is costly and frequently results in the out-migration of the trainee. The USAID comparative advantage in capacity building is linked closely to improvements in on-the-ground services and health indicator results, rather than generalized systems support. USAID has relatively little advantage in areas, which are dominated and funded heavily by other partners. Two important examples are polio eradication efforts and leprosy programs.

VII. PROGRAM PARMETERS AND CRITERIA

This section lists the program parameters and criteria that informed the Team's analysis and recommendations. It is based mainly on guidance from USAID/Nigeria. They are:

1) To the maximum extent possible, activities will be integrated in terms of technical content within the health/education sector (CS, RH, HIV/AIDs, education) and across other sectors, such as democracy and governance and agriculture. USAID plans one strategic objective (SO) for HIV/AIDs and a second SO combining health, nutrition, population and education.

2) USAID will retain its focus on programs that have "community level impact" and particularly community programs, which empower local communities to take action to define and resolve their own problems.
3) USAID strategies will emphasize potential for leveraging (other donors, government at central, state and LGA levels and communities), through programs utilizing USAID comparative advantages and program designs facilitating scaling up programs. Since virtually all child survival projects funded currently by USAID are small, the potential to scale up and leverage resources is the operative criterion in assessing models and modalities.

4) Management streamlining (currently underway) of the USAID portfolio will enhance efficiency, prevent duplication and fragmentation and multiply results. A subset of this is using evidence of effectiveness and impact based on sound data. Increasingly, these criteria also are being applied to IP's.

5) USAID programs endeavor to take into account the vast geographic, cultural and religious differences that make up Nigeria. For political reasons, the program needs to have geographic spread. Some aspects, such as ITN marketing, will operate nationally. Even so, USAID will

plan in such a way that some aspects of the program are based in each of the main geographic zones. Given the small size of the CS program, this is a "Catch-22" in terms of impact and scale. A positive aspect is the role geographically balanced on-the-ground programs can play in informing national policy agendas. To the extent possible, the goal of multiculturalism should be applied to staffing, participant training and other program inputs.

6) USAID/Nigeria is committed to having a program that incorporates the current state of the art in all its technical areas as well as the current thinking on program design and monitoring and evaluation. Overall, USAID/Nigeria has the political pull within USAID and the financial resources to demand a program of excellence. Limited child survival funding to address increasingly dire child health and nutrition indicators may be the one exception, unless the program can leverage funds or benefit from earmarks. Putting into place the right mechanisms to access and manage a "best practices" approach will require creativity and persistence.

7) Implied within all USAID-funded programs is a requirement to put into practice the principles of sound governance and fiscal responsibility. Apart from this, there may be ways to use the "track records" of the States, LGAs and NGOs that already practice sound governance as part of selection criteria for health or education programs. This both rewards sound governance and allows programs to function, with hope that counterpart funding will actually materialize.

VIII. "THE WAY FORWARD"- CONCLUSIONS AND FIVE YEAR STRATEGY RECOMMENDATIONS FOR CHILD SURVIVAL

Nigeria is large and complex, and its child health problems seem intractable. Although incremental gains are being made in some areas and there are a number of promising programmatic approaches, overall, the survival of Nigerian children depends more on internal geopolitical and social reform than on anything a donor can fund. When queried, many Nigerian informants spoke movingly of their hope-and prayer- that the "way forward" for Nigerian children lies in growing Nigeria's democracy and curbing corruption.

Nigerian informants and other stakeholders provided many sound recommendations, which the team validated and distilled into broad strategic recommendations. Specific technical suggestions can be found in the analysis of each technical area or separate memorandum to the HPN/O.

General Program Recommendations

RECOMMENDATION # 1: INTEGRATE

Integration as a principle is a positive force for efficiency and effectiveness. In implementing its integrated approach, USAID needs to:

- Carefully take into account the wider environment, particularly the myriad of departments, policies, ministries, donor-stakeholders, etc. at the national level that inhibit one unified approach. USAID and its partners will still need a seat at many tables.
- States and LGAs may offer lower cost models of promoting integration across sectors. For example, the State Councils for Health (multi-sectoral advisory groups) could be revitalized in priority states.
- Synergies between technical areas need to be incorporated into the program without affecting the quality of SOTA technical inputs. The strategy should be elaborated to incorporate ongoing

mechanisms to tap USAID central expertise and flexibility to alter programmatic courses should new health challenges or solutions emerge.

- Community approaches and service delivery should be integrated to the maximum extent possible. This is where integration is both feasible and in demand.
- The private sector needs to be encouraged to adopt/adapt integrated approaches; emphasis on public-private partnerships should continue.

RECOMMENDATION # 2 : TIGHTEN POLICY AND RESEARCH AGENDAS

Clear mechanisms are needed for USAID to develop and update a highly focused policy and research agenda, with mechanisms to exclude issues or research that is marginal to central issues, then to carefully monitoring progress on key policy issues and the overall policy environment as it evolves. Policy analysis and action should respond rapidly to address barriers such as vaccine supply, taxes and tariffs on ITNs and release of funds to LGAs. In the long term, issues around health sector reform, quality of services, equity, budget, taxation and cash flow should be priority. USAID should rethink its objectives in supporting applied and operations research, and maintain closer control of the research agenda. Operations research is defined as research embedded within programs and driven by program questions. Operations research needs to be carried out quickly and efficiently. The balance in policy and research needs to be tipped toward the "must be resolved" issues, away from the "good to accomplish" ones. Currently, the balance leans more toward the latter.

RECOMMENDATION # 3 : DEVELOP AN INTEGRATED BCC APPROACH

USAID and its partners must evolve a behavior change and communication (BCC) strategy that is comprehensive, cross-sectoral, evidence-based, culturally sensitive and focused on outcomes (i.e. household and individual behaviors) rather than knowledge.

Specifically, the long term BCC strategy needs to:

- Be based on sound research and behavior change theory;
- Incorporate good monitoring and evaluation of impact (linked to services);
- Use "message guides" to insure consistency of technical advice, but use current knowledge (which is extensive) of cultural practices (especially in nutrition) to adapt messages regionally to be acceptable and doable by target populations;
- Focus on "small, doable actions" and changing community norms;
- Be integrated across health/education sectors and from mass media to community counseling levels;
- Focus on face-to-face encounters (67% of impact is achieved here) and community mobilization;
- Shift from predominantly product-oriented (e.g. poster, jingle, TV spots and heavy reliance on ad agencies for creative work) to a broader programmatic approach, of which mass media is one important component;
- Produce higher quality, more appealing materials;
- Share the "credit" for any material produced with the broadest possible group of stakeholders, whether they contribute financially or not;
- Produce materials that can be "leveraged" (i.e. purchased by other donors); and
- Insure an adequate "density" of penetration in combined BCC efforts (mass media, community mobilization, print materials, individual counseling) in a given community before launching an IEC effort.

RECOMMENDATION # 4: EXPAND PUBLIC-PRIVATE PARTNERSHIPS

The USAID portfolio is currently well balanced in the use of NGO partners linked to public sector and commercial or social marketing efforts. The private sector offers a crucial link to populations and a "safety net" when/if public sector programs fall short. It is noted that the HIV/AIDS program, by virtue of its generous funding and wide mandate, is programming diversely and extensively in the private sector. Whenever possible (that is, nearly always), child survival should be integrated as part and parcel of these efforts. HIV/AIDS is a child survival issue!

The team recommends continuing, and possibly expanding, public-private partnerships by:

- Seeking non-labor or investment intensive models for supporting NGOs;
- Working with private sector health providers (hospitals, clinics, private midwives);
- Supporting and expanding commercial and social marketing efforts;
- Revitalizing the USAID work-based services approach;
- Mobilizing the private sector to come to the table on key policy issues;
- Exploring pre-packaged, quality controlled pharmaceutical products (e.g. anti-malarials) with distribution networks to include the Patent Medicine Vendors.; and
- Involving the uniformed services in CS approaches, not just in HIV/AIDS.

RECOMMENDATION # 5: DESIGN EVIDENCE-BASED AND DATA DRIVEN PROGRAMS

Careful work in setting performance targets, programmatic benchmarks, and monitoring and evaluation protocols will make or break the new USAID strategy. Program goals and objectives, like behavior change targets, must pass very strict "achieve-ability" criteria, with levels of funding taken into account. USAID cannot provide materials to bake a cupcake, then request a wedding cake. Currently, the use of evidence and data is not strong either with partners (such as the Ministry of Health) or in USAID/Nigeria-funded health programs. Communities and NGOs are frequently unaware of their service (immunization, family planning, ANC) targets--or set them way too low. At the IP level, data is sometimes unavailable, difficult to access and not standardized. Nevertheless, good progress is being made in attacking these problems. USAID needs to place maximum emphasis and provide sufficient funding in this critical area, both to inform the new strategy and throughout the next six years. However, it is important to monitor M&E assistance and advice to insure that it is practical and doable and not based on highly theoretical or untested models. To the extent feasible, routine data needs to come from existing HMIS at local levels, backed up by DHS, MICS, special studies and operations research.

Summary of Program Area Recommendations:

RECOMMENDATION # 6: IMMUNIZATION

- Modify strategy to focus on routine immunization;
- Engage the remaining polio resources carefully to not detract from routine immunization. Use polio campaigns to strengthen routine immunization and attach any support to polio and NIDs to promotion of routine immunization.
- With GAVI and ICC partners, guarantee the flow of resources and vaccines to 774 LGAs and as a policy force to refocus and strengthen the immunization program.
- Ensure PVO and private health institutions' vaccination capacity, as a back-up to the public sector.

RECOMMENDATION # 7: MALARIA

Malaria remains the first killer of young children in Nigeria. The Nigerian government and its partners participate in the Roll Back Malaria program. For USAID/Nigeria, malaria prevention and treatment should remain a priority in the three major RBN areas:

- Continue ITNs through NetMark;
- Reinforce prompt and appropriate community level fever treatment;
- Link IPT (intermittent pregnancy treatment) through reproductive health services; and
- Strengthen community mobilization and efforts targeted at most vulnerable groups.

RECOMMENDATION # 8: NUTRITION

Many potentially important efforts in nutrition are ongoing. There is a need, however, to adopt a more rational and "holistic" approach around key behaviors with proven impact on child health (e.g. Essential Nutrition Actions).

The five-year strategy should:

- Maintain USAID's leadership in supporting the development and implementation of a national routine vitamin A supplementation strategy for children 6-59 mo of age (present policy is calling for 6-24 mo), as well as strengthening the capacity of PHC facilities to administer VA capsules in the case management of measles, severe diarrhea, PEM, and xerophthalmia.
- Provide technical assistance and support to the National Fortification Program in conjunction with GAIN, focusing on VA, iron, folate, and iodine fortification of commonly consumed foods.
- Support the establishment of a national nutrition and food security surveillance system for ongoing program monitoring and needs assessment.
- Explore the potential and opportunities to accelerate and expand the release of "biofortified" lines of key crops, particularly high iron and zinc varieties of maize and legumes developed at the International Institute of Tropical Agriculture/Ibadan (IITA).
  Support an integrated approach to reducing maternal and pediatric anemia, including targeted supplementation and food fortification (VA, iron, folate and other B-vitamins), RBM (ITNs, case treatment, IPT) and deworming, through antenatal/postnatal care, PHC facilities, and community-level programs.
- Approach PMTCT as a child survival issue, linking VCT, ANC, maternal health and nutrition, FP, ARVs, infant feeding counselling and support, and basic child health interventions (EPI, CDD, ARI, VA, malaria), addressing the needs of all children in households where mothers (and frequently fathers) are HIV+.
- Develop infant feeding strategies cooperatively across CS, FP and PMTCT sectors.

Very specific transition recommendation are found in annex E.

RECOMMENDATION # 8: OTHER CHILD SURVICAL INTERVENTIONS

Unless additional funding becomes available, it will be impossible to support these interventions on a large scale. However, USAID should seek opportunities to reinforce and support ongoing programs in these areas with non-costly interventions. For example, ORT and ARI should be included in the integrated BCC strategy, and the ubiquitous "ORT corners" can be revived by community action groups with very little investment. Revisions to curricula or standing orders can encompass updating ARI and ORT advice, and USAID can follow policy-level discussions.

IX. RECOMMENDATION FOR THE TRANSITION PERIOD

We spend too much time talking about coordination and collaboration … [but] we collaborate more than we give ourselves credit for.

RH NGO Representative

In the transition period until its new strategy is fully implemented, USAID will undertake selected activities to further inform its analytic agenda and to ease the transition into a new integrated strategy. The team has made recommendations with this in mind, taking care to recommend transition activities that can be completed at low cost or within existing funded programs. USAID has identified its structural problems, such as too many IP's, lack of coordination, "stove piping" and over-dependence on central projects, that impeded efficient implementation. Structural changes will greatly improve things. However, the fragmentation of activities, capacities and programs by sector and even sub-sector goes deeper than contracting structures. Success in achieving USAID objectives will involve fundamental changes in attitudes and practices of the local partner staffs, some of whom have been working with USAID programs for years. Thus, transition recommendations focus on activities designed to yield a gradual evolution of the program toward an "integrated outlook" and polyvalent technical capabilities in as consensual and non-threatening way as possible.

Transition Recommendation #1: Strengthen Health Financing Knowledge (Analytic Agenda)

Additional analyses or information gathering should be done in this important area. Specifically, an analysis and description of various health financing issues, including government budget allocations (by Central, State, LGA) and experiences in flow-down of funds. The analysis should look at PHC, community Bamako Initiative type financing, (documenting communities that are still capitalized and those where funding has been drained), financing of vaccines and essential drugs, and allocation and financial management. A few "case examples" of specific states, LGAs and NGOs, especially those performing well on governance and financial discipline criteria, would be helpful in projecting potential sustainability of programmed activities. It is likely that macro level analysis or even much of the needed information exists through the World Bank or DFID. To elaborate its strategy, USAID needs access to a more in-depth review of financial management and planning in health (and education) sectors and a validation of priority policy agenda.

Transition Recommendation # 2: Inventory/Annotate Policies, Norms, Standing Orders and Curricula (Analytic Agenda)

A team should be organized with representatives from USAID, IP's, Government and one or two expert consultants to conduct an across the board inventory and technical (i.e. content and presentation) review of all "guidance" materials being used in the public sector (and private sector if time allows). These include:

- "Standing Orders" in all technical areas;
- Bamako Initiative Procedures Folders;
- Manuals for In-service and community volunteer training;
- Policies/policy documents (FP, RH, Safe Motherhood, Breastfeeding, Nutrition, ITM, Malaria Control, etc.);
- International conventions and charters Nigeria has signed (e.g. ICPD, Rights of the Child, etc.);
- Norms and Standards for licensing PMVs;
- Curricula for training nurse-midwives, doctors and CHEWS; and
- NGO policies, procedures, manuals and training curricula as they relate to the above norms and standards.

For efficiency, this inventory should be conducted across sectors (CS, RH, HIV/AIDS, and education). Audits of selected sites would determine the extent of knowledge and utilization of these policies, standards and job aids. A key output would be to identify and "red flag" areas where technical updating or harmonization is required, and to evaluate and make recommendations on dissemination. One area of particular importance is harmonization of guidelines for PHC and IMCI. Treatment algorithms may be dated, and "new" advice, such as Emergency Contraception or double protection (FP and HIV) may not be present.

Judging from a rapid review of what is available, many manuals and other materials could be made more "user friendly" and attractive/readable. A future activity would be to harmonize various program-specific materials (e.g. BASICS, UNICEF, Engender Health, etc.) and put logos of all USAID and other donor partners and relevant ministries on the resulting materials. This is an effective way to leverage reproduction/distribution costs and produces better collaboration. Everyone gets "credit" for success.

Transition Recommendation #3: Inventory, Integrate, Innovate in BCC (Integration Agenda)
Currently, the bulk of USAID-funded IEC support (mass media, print media) is provided by JHU/CCP. They are undergoing an internal process of developing an integrated framework for a more comprehensive approach to behavior change and communications. This is a very good start; it needs to be shared and validated by stakeholders. The bilateral VISION Project also has begun this process. Regarding the BCC efforts housed within IP's work must be shared, updated and available among partners. "Credit" for technical productions needs to be shared . Other groups, such as PSI and NetMark, have BCC approaches that can be shared/enhanced within a wider strategy. Voice of America is entering the health communications sphere and may add dynamism to the mix.

The current BCC efforts in Nigeria are dominated by a piecemeal mass media production approach, rather than a "bottom up" and comprehensive behavior change model. Visual materials are by and large not very attractive, and some convey mixed or confused messages. BCC for Child Survival in Nigeria (and possibly other health areas) needs an injection of enthusiasm and innovation and a strong strategic perspective based on sound behavior change theory and well defined messages. All this is unlikely to be achieved during the transition period. However, external technical assistance to initiate this process is recommended.

Transition Recommendation #4: Harmonize and Synergize Community Approaches (Integration Agenda)
The multiple community "approaches" in Nigeria have many common elements. To begin the process of harmonizing models of working at the community level, a small working group should be formed, composed of experienced community mobilization experts and strategic thinkers. Those invited should included key thinkers on community from Government (i.e. NPHCDA), foundations (e.g. Tulsi Chandrai, Packard), USAID agriculture (farmer to farmer programs), education (LEAP), former DFID PHC projects and UNICEF. The objective is not to exchange ("show and tell"), but rather to identify common approaches and problems. Cross over site visits should be organized. The focus should be on sharing and evolving a process, rather than coming up with a single "mandated" approach. On the other hand, evolution of common approaches, not "branded" (i.e. associated closely with one or another IP or stakeholder), would be encouraged. The emphasis would be individuality with commonality, but no proprietary approaches or materials.

Areas to be considered include:

- Potential to scale up/work on a large scale;
- Community decision-making;
- Techniques for mobilization of communities and changing community norms on household behaviors (including materials for community mobilization);
- Training community leaders and volunteers (length, content, skills, training aids);
- Cost sharing and cost containment (opportunities to reduce the cost of external financial and technical inputs);
- Integrating activities across sectors (immediate opportunities for synergy between IP programs); and
- Collecting and utilizing data at the community level (community monitoring or health facilities and advocacy).

Transition Recommendation #5: Cross-Train IP Staff (Human Resource Development)

In the upcoming strategy, USAID will move into an integrated mode for programming and technical support, particularly at the community level. Currently, IP staff are highly experienced, but often function in specialty areas and have inadequate knowledge of other sectors. To run its integrated program, USAID will need polyvalent program officers and technical staff. USAID should begin soon, and at the lowest possible cost, the process of cross training IP staff, providing more in-depth knowledge of technical areas outside their current specialty. This should be technical in-service leading to specific clinical and programmatic knowledge that can be evaluated (e.g. post tests, skills assessments, role plays). For example, a two-three day seminar (or two identical seminars planned at different dates/locations to accommodate varying schedules) on malaria would include a comprehensive briefing on SOTA (specifically issues on treatment protocols), RBM initiatives internationally and in Nigeria, ITN promotion strategies (and the roll communities can play), and M&E for malaria control. Each participant would be sponsored by his/her IP, and participation should be entirely voluntary. It is likely that IP staff will perceive the advantages of cross training without being coerced. USAID should provide certificates of participation.

Recommendation #6: Analyze Vaccine and Essential Drugs Capacity (Analytic Agenda)

The team received mixed reports on the capacity and training needs within the overall three-tiered health system to manage logistics (forecasting needs, stock control, cold chain management, transportation, etc.) for the immunization program and for essential drugs. Clearly, the current, mainly "push" system is not working, but there are many theories as to the root causes. USAID already invests in a strategic approach to contraceptive logistics through the DELIVER Project. It might consider a similar analysis in the area of vaccines and, if feasible, essential drugs. This would enable USAID to determine whether there are points within the supply system where "targeted" interventions would be helpful. However, UNICEF and WHO should remain the key donors in equipment and vaccines for the NPI.

Recommendation # 7: Link Research With Policy and Performance Indicators

Despite an initial exercise to prioritize research topics, some of the applied research being funded by ARCH is relevant to current program issues; some is not. It is not clear that USAID has a sufficiently flush CS budget to support AR in a serious way. Research and analysis undertaken by the Policy Project does not appear to be linked to the interesting "position papers" being generated by ARCH. In the transition period, USAID should encourage links between policy and research, maximize research links to programs and "rethink" the role of applied and operations research across the health/education sector. Research also needs to be linked to monitoring and evaluation of key indicators, with priority given to research that helps explain why some things are or are not working. An example would be

sentinel studies to determine the extent that commercially marketed ITNs reach key target groups (poor pregnant women and very young children living in poverty). USAID and the IP's are on track and making good progress in improving the quality of data and indicators. This will pay off in the new strategy. Villages and communities need "denominators" (i.e. target populations to be served) to monitor their own progress.

Four Urgent Needs!

- Address the issue of Taxes and Tariffs on nets, yarn and insecticide for ITNs. Be on the "look out" for similar issues in upcoming plans for food fortificants.
- Address the problem of vaccine stock-outs, initially and urgently in LGAs where BASICS and other IP's operate. "No Product, No Program!"
- Follow on the launching of the National Nutrition Policy with a Plan of Action. Insure multi-stakeholder involvement and integration of Food Security and a rational approach to "Essential Nutrition Actions".
- Given the effect of HIV/AIDS on the nutritional status and health of entire households, USAID/Nigeria should be actively engaged with government and partners in Nigeria to develop comprehensive HIV/AIDS care and support guidelines to ensure that programs recognize and provide support to these vulnerable households. This would include directing Title II assistance to vulnerable households (potentially identified by food deficits/insecurity rather than by HIV-infected individuals if stigma is an issue).

And on a lighter note…

- **Synergy Awards** could be given to IP's for synergistic activities. Winners can be identified in the course of routine Annual Report and Portfolio Review process.
- **"No Protocol" Training** can add as much as a half day to any workshop or training, producing significant cost savings. Eliminate or restrict time on "opening" and "closing" ceremonies. Alternatively, begin training promptly and interrupt it when the guest of honor arrives for his/her kick-off speech (only one speech).
- **Partner Fairs** provide a lively and interesting alternative to lengthy presentations at IP meetings. IP's and other partners are invited to put together a booth with posters on key studies and findings, materials used, videos produced, etc. The IP meeting becomes a celebration of success! Posters can then be displayed for the general public at USAID or the American Cultural Center.

Closing

The assessment team appreciates the opportunity to contribute to the development of the exciting new USAID/Nigeria health/education strategy. Nigeria is, indeed, the most interesting and important country in Africa, and USAID has a vital role to play.

ANNEX E : Recommendations for the Transition Period: Nutrition

- Include a team member on the upcoming USAID/Nigeria Agriculture Sector Assessment who can examine the links between agriculture, food security, nutrition and health.

- Work with key partners (FMOH, NPC/NCFN, UNICEF, WHO, BASICS, HKI) to develop post-NID strategies for routine (semi-annual) VA supplementation at Federal, State, and LGA levels. Explore Child Health Day/Week model, which could build on HKI VA/CDTI model. May be different state by state.
- Support and provide technical assistance to the Nutrition Division/FMOH and other stakeholders to develop a National Plan of Action for Food Fortification and a Global Alliance for Improved Nutrition (GAIN) National Food Fortification Program Implementation & Strengthening Grant proposal for submission in 2003. [Note: Increased interest in Nigeria in nutrition and chronic disease strengthens rationale for fortifying commericial flours (wheat and maize) with folic acid.]
- USAID/N and UNICEF/N should jointly support a small delegation of key Nigerians (including Liane Adams) involved in developing the National Nutrition Plan of Action and the National Plan of Action for Food Fortification, particularly the post-NID routine vitamin A supplementation programs and the GAIN proposal, to attend the International Vitamin A Consultative Group (IVACG) and International Nutritional Anemia Consultative Group (INACG) Meetings in Marrakech, Morocco February 3-10, 2003.
- Support IITA and partners in conducting full analyses of data from the National Food Consumption and Nutrition Survey and assure that these analyses inform the development of the National Nutrition Plan of Action and associated policies and programs.
- Include anemia (HemoCue) assessment in 2003 DHS and secondary nutrition analyses of DHS data.
- Develop PMTCT and infant feeding strategy with CDC/Nigeria and other partners with strong links to VCT/ANC and primary CS services.
- Examine evidence that routine deworming would improve health, cognitive development, and educability of children (preschool- and school-age), as well as health and birth outcomes for pregnant women.
- Request support from USAID/W (GH and EGAT) for studies on the bioavailability of iron and zinc in "biofortified" lines of maize and legumes developed at IITA.
- The proposed "piloting" of double fortification of salt (iodine + iron) should be approached with caution. Double fortification would require industry investments in the quality of salt, as well as incurring the additional cost of iron. While salt iodization has the potential for unsubsidized commercial production (~5% increase in retail price to cover iodization costs), double fortification would like be unsustainable commercially. Consequently, the public sector would have to indefinitely subsidize the costs and bear the costs of both intensive internal monitoring (the added costs increasing the incentive for producers to cheat) and to restrict the cross-border flow of properly iodized salt from contiguous countries.
- Because of the effects of HIV/AIDS on the nutritional status and health of entire households, USAID/N should be actively engaged with government and partners in Nigeria to develop comprehensive HIV/AIDS care and support guidelines and ensure that programs recognize and provide support to these vulnerable households. This would include directing Title II assistance to vulnerable households (potentially identified by food deficits/insecurity rather than by HIV-infected individuals if stigma is an issue).
- USAID/N should be engaged with and assist the GON to revise and implement Standing Orders/guidelines for the clinical diagnosis and treatment of HIV+ infants and children.
- Broaden discussion of tax/tariff relief for ITNs to cover fortificant (and other health commodities).
- Review World Bank Nutrition Program Review (Rae Galloway, 2002).